Registration & Medical History

hartville health & wellness centre

Todays Date_____ Birthdate_____

Name _____

Address _____

City_____State_____Zip_____

Phone Numbers _____ _____

Email_____

Gender _____ Social Security Number_____

Marital Status _____ Employment Status_____

Employer/School_____

Race_____ Preferred Language_____

Multi-Racial ? Yes No Unknown Hispanic or Latino? Yes No Unknown

Verification Question to access your information in patient portal:

What city & state were you born in? _____

How did you hear about our office?_____

General Health & Wellness

Smoking: ___Never ___Previous ___Current

If currently a smoker how many packs per day?_____

How much & type of exercise?

_____

_____

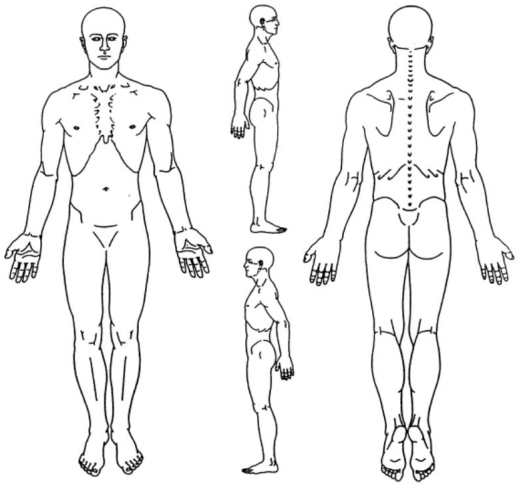
Are you a healthy eater? ___Yes ___No

What could you do to improve your health?

_____

_____

How much sleep per night?_____



Mark an X on the picture anywhere you have pain, numbness, or tingling.

Rate your pain on a scale from 0-10

0 = no pain 10 = severe

0 1 2 3 4 5 6 7 8 9 10

Reason for visit? _____

_____

_____

When did your symptoms appear or date of injury?_____

How often do you have this pain? _____

_____

(Circle all answers that apply):

Is this condition getting progressively worse? Yes No Unknown

Type of pain: Dull Sharp Throbbing Burning Deep Aching Tingling Stabbing Cramping Numbness Radiating

Does it interfere with your: Work Sleep Routine Recreation

Activities or movements that **AGGRAVATE** the pain: Sitting Standing Walking Bending Lifting Coughing Twisting Lying Down

Activities or movements that **RELIEVE** the pain: Sitting Standing Lying Down Movement Heat Ice Medication Stretching

What else should we know about your condition?_____

_____

Review of Body Systems (CHECK ALL THAT APPLY)

Musculoskeletal:
__Osteoporosis
__Arthritis
__Scoliosis
__Neck Pain
__Back Problems
__Hip disorders
__Knee Injuries
__Foot/Ankle Pain
__Shoulder Problems
__Elbow/Wrist Pain
__TMJ Issues

Neurological:
__Anxiety
__Depression
__Headache
__Dizziness
__Pins & Needles
__Numbness

Sensory:
__Blurred Vision
__Ringing in Ears
__Hearing Loss
__Chronic Ear Infection
__Loss of Smell/Taste

Cardiovascular:
__High Blood Pressure
__Low Blood Pressure
__High Cholesterol
__Poor Circulation
__Angina
__Excessive Bruising

Integumentary:
__Skin Cancer
__Psoriasis
__Eczema
__Acne
__Hair Loss
__Rash

Respiratory:
__Asthma
__Apnea
__Emphysema
__Hay Fever
__Shortness of Breath
__Pneumonia

Endocrine:
__Thyroid Issues
__Immune Disorders
__Hypoglycemia
__Frequent Infection
__Swollen Glands
__Low Energy

Genitourinary:
__Kidney Stones
__Infertility
__Bedwetting
__Prostrate Issues
__Erectile Dysfunction
__PMS Symptoms

Constitutional:
__Fainting
__Low Libido
__Poor Appetite
__Fatigue
__Sudden Weight Gain/Loss
__Weakness

Digestive:
__Anorexia
__Bulimia
__Ulcer
__Food Sensitivities
__Heartburn
__Constipation
__Diarrhea

Are there any previous/current illnesses we have not covered in this questionnaire?

_____

_____

List any medications you are ALLERGIC to:_____

Medication List:	Start Date	Medication List:	Start Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Hospitalizations: (past 5 yrs.)

_____ _____

_____ _____

Surgeries:

_____ _____

_____ _____

Major Family Medical History:

_____

Have you consulted a Chiropractor before? ___Yes ___No Date_____

If yes, please provide the name: _____

Name of your Primary Care Physician: _____

Name of any other Health Care Providers whose care you are under:

_____

_____

T.C. #_____

For Office Use Only:

HEIGHT:_____inches

WEIGHT:_____lbs.

Blood Pressure /