Registration & Medical History

Todays Date________________________ Birthdate________________________

Name ____ Gender________

Address ____

City____State_______Zip___________

Phone Numbers ____________________________ ____________________________

Email_____________________________________ S.S.#_________________________

Marital Status __________________ Employment Status___________________

Spouses/Parents birthdate if under their insurance:_____________________

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?_____

EAT Do you eat healthy? ____________________

MOVE What do you do for exercise? _________

____

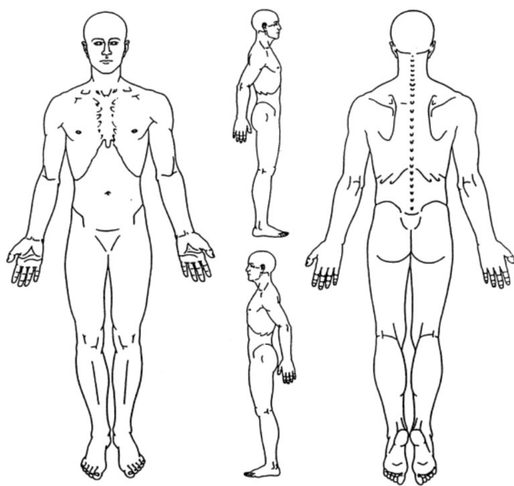
SLEEP How many hours do you sleep per night?

____ 4 to 6 ____ 6 to 8 ____ 8 to 10

What else could you do to improve your health?

____

____



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? (Please check one)

Occasional (1-25%) ____ Intermittent (26-50%) ____

Frequent (51-75%) ____ Constant (76-100%) ____

(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

Cardiovascular:

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

Respiratory:

__Asthma
__Apnea
__Emphysema
__Hay Fever
__Shortness of Breath
__Pneumonia

Genitourinary:

__Kidney Stones
__Infertility
__Bedwetting
__Prostate Issues
__Erectile Dysfunction
__PMS Symptoms

Digestive:

__Anorexia
__Bulimia
__Ulcer
__Food Sensitivities
__Heartburn
__Constipation
__Diarrhea

Sensory:

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

Integumentary:

__Skin Cancer
__Psoriasis
__Eczema
__Acne
__Hair Loss
__Rash

Endocrine:

__Thyroid Issues
__Immune Disorders
__Hypoglycemia
__Frequent Infection
__Swollen Glands
__Low Energy

Constitutional:

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

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 his name.____

Name of your Primary Care Physician.______________________________________

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

____
____

For Office Use Only:

HEIGHT:__________inches

WEIGHT:___________lbs.

Blood Pressure /

R L arm wrist