CHIROPRACTIC REGISTRATION

Date: ______________________ Social Security No. : ______________________

Name: ______________________ Address: ______________________

City: ______________________ State: ________ ZipCode: ______________________

Home Phone: ______________________ Business Phone: ______________________

Fax: ______________________ **Cell Phone** ______________________

Birthdate: ______________________ Age: ______________ Sex: ☐ M ☐ F

Employer: ____

Address: ____

City: ______________________ State: ________ ZipCode: ______________________

☐ Student ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated No. of Children: _____

Name of Emergency Contact: ______________________ Phone No.: ______________________

Spouse's Name: ____

Birthdate: ______________________ Social Security No.: ______________________

Employer: ______________________ Phone: ______________________

Address: ____

City: ______________________ State: ________ ZipCode: ______________________

Whom may we thank for referring you? ______________________

Insurance:

Insurance Co.: ____

Subscribers Name: ____

Insured: Check One: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Birthdate: ______________ Social Security No.: ______________ Insurance #______________

Group #: ______________

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance Co.: ____

Subscribers Name: ____

Insured: Check One: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Birthdate: ______________ Social Security No.: ______________ Group #: ______________

Accident Information:

Is condition due to an accident? ☐ Yes ☐ No Date: ______________

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other ______________________

Attorney Name (If applicable): ____

I understand that insurance is an arrangement between the insurance carrier and myself. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to obtain payment of benefits. I authorize the use of this signature on all insurance submission.

"I acknowledge that I have had an opportunity to view and/or receive a copy of the Provider's Notice of Privacy Practice"

Patient's Signature: ______________________________ Date: ______________

CHIROPRACTIC HEALTH QUESTIONNAIRE

Date: ______________________

Patient Name: ______________________ Birthday: ______________________

Reason for Visit: ______________________

Have you been treated before for this problem ☐ Yes ☐ No

If yes, by ☐ MD ☐ Chiropractor ☐ Physical Therapist ☐ Osteopath ☐ Other ______________________

What did they recommend: ______________________

What caused the problem: ______________________

When did the symptoms appear: __________ Is this condition getting worse: ☐ Yes ☐ No

Is it constant or does it come and go? ______ Does it interfere with your ☐ Work ☐ Sleep ☐ Dailey routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down

☐ Other ______________________

Your Occupation ______________________
(Describe activities-sitting, lifting, etc.)

Have you ever had Chiropractic care for other problems? ☐ No ☐ Yes When? ______________________

Do you take ☐ Muscle relaxers ☐ Pain Killers ☐ Insulin ☐ Birth control pills ☐ Over the counter meds

Other Medications you are currently taking	Vitamins/Herbs/Minerals
Allergies	
Pharmacy Name: Phone:	

Date of last:			
Physical Exam ______	Spinal x-ray ______	Blood test ______
Spinal Exam ______	Chest x-ray ______	Urine test ______
Dental x-ray ______	MRI, CT-scan, Bone scan ______	

CONDITIONS Check (√) you have or have had in the past.

☐ Aids	☐ Diabetes	☐ Liver disease	☐ Rheumatic fever
☐ Alcoholism	☐ Emphysema	☐ Measles	☐ Scarlet fever
☐ Anemia	☐ Epilepsy	☐ Migraine headaches	☐ stroke
☐ Anorexia	☐ Fractures	☐ Miscarriage	☐ Suicide attempt
☐ Appendicitis	☐ Glaucoma	☐ Mononucleosis	☐ Thyroid problem
☐ Arthritis	☐ Goiter	☐ Multiple sclerosis	☐ tonsillitis
☐ Asthma	☐ Gonorrhea	☐ Mumps	☐ Tuberculosis
☐ Bleeding disorders	☐ Gout	☐ Osteoporosis	☐ Tumors, growths
☐ Breast Lump	☐ Heart disease	☐ Pacemaker	☐ Typhoid fever
☐ Bronchitis	☐ Hepatitis	☐ Pneumonia	☐ Ulcers
☐ Bulimia	☐ Hernia	☐ Polio	☐ Vaginal infections
☐ Cancer	☐ Herpes	☐ Prostate problem	☐ Venereal disease
☐ Cataracts	☐ High Cholesterol	☐ Prosthesis	☐ Whooping cough
☐ Chemical Dependency	☐ HIV positive	☐ Psychiatric care	☐ Surgeries ______
☐ Chicken pox	☐ Kidney disease	☐ Rheumatoid arthritis	☐ Other ______

List any family members who have or have had any of the above conditions: ______________________

General Symptoms Check (√) symptoms you currently have or have had in the past year.

General
- ☐ Chills
- ☐ Dental Problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Tiredness
- ☐ Weight gain

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nose bleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-Flashes
- ☐ Vision-halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change of Moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other
- ☐ Date of last menstrual period ____________
- ☐ Date of last Pap smear ____________
- ☐ Have you had a mammogram? ____________
- ☐ Are pregnant? ____________
- ☐ Number of Children ____________

NECK, BACK, EXTREMITIES Check (√) symptoms you currently have had in the past year.

NECK	Right	Left
☐ Neck pain	☐	☐
☐ Neck stiffness	☐	☐
☐ Neck weakness	☐	☐
☐ Pinched nerve in neck	☐	☐
☐ Neck feels out of place	☐	☐
☐ Muscle spasm in neck	☐	☐
☐ Grinding/popping in neck	☐	☐

SHOULDERS	Right	Left
☐ Pain in shoulder joint	☐	☐
☐ Pain across shoulders	☐	☐
☐ Can't raise arm	☐	☐
☐ Above shoulder level	☐	☐
☐ Overhead	☐	☐
☐ Tension in shoulders	☐	☐
☐ Pinched nerve in shoulder	☐	☐

MID-BACK	Right	Left
☐ Mid-back pain	☐	☐

- ☐ Mid-back stiffness
- ☐ Pain between shoulder blades
- ☐ Pain from front to back
- ☐ Muscle spasm in mid-back

ARMS & HANDS	Right	Left
☐ Pain in upper arm	☐	☐
☐ Pain in elbow	☐	☐
☐ Pain in forearm	☐	☐
☐ Pain in hand	☐	☐
☐ Pain in fingers	☐	☐
☐ Pins & needles in arm	☐	☐
☐ Pins and needles in fingers	☐	☐
☐ Numbness in arm	☐	☐
☐ Numbness in fingers	☐	☐
☐ Weakness in arm	☐	☐
☐ Weakness in hand	☐	☐
☐ Hands cold	☐	☐

LOW BACK	Right	Left
☐ Low back pain	☐	☐

- ☐ Low back stiffness
- ☐ Low back weakness
- ☐ Pinched nerve in low back
- ☐ Low back feels out of place
- ☐ Muscle spasm in low back

HIPS, LEGS, & FEET	Right	Left
☐ Pain in Buttocks	☐	☐
☐ Pain in hip joint	☐	☐
☐ Pain down leg	☐	☐
☐ Pain in Knee	☐	☐
☐ Pain in ankle	☐	☐
☐ Pain in foot	☐	☐
☐ Weakness of leg	☐	☐
☐ Weakness of knee	☐	☐
☐ Leg cramps	☐	☐

OTHER SYMPTOMS

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____

____

____

____

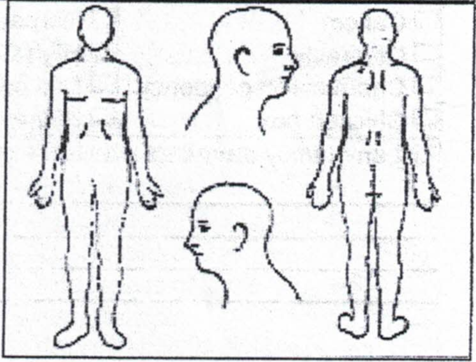
Place an **X** on the drawing to the right on the areas causing your pain and the letter describing it.

PAIN SCALE

Please circle the number that best describes the pain

0	1	2	3	4	5	6	7	8	9	10
NONE				LITTLE			MEDIUM			SEVERE

A=ACHE
B=BURNING
S=STABBING
N=NUMBNESS
P=PINS & NEEDLES
D=DULL



I certify that the above information is correct to the best of my knowledge.
I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature ____________________ Date ____________

Doctors Signature ____________________ Date ____________