The Joint
Chiropractically….Cleveland
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Chiropractic Registration and History

Name:_____Today's Date:_____
(as appears on Medicare Card)
Residential Address:_____

Suburb_____ State:_____Postcode:_____

Phone/Mobile:_____Email Address:_____

Date of Birth:_____Age:_____Occupation:_____

Marital Status:_____Number of Children:_____

Emergency contact Name:_____Relationship:_____PH:_____

Health Insurance: **Y** or **N** Name of Health Fund:_____

How did you find us?_____

Reason for visit:_____

When did your symptoms first appear?_____

Is your condition getting progressively worse?_____

Rate the severity of your condition (0 least – 10 severe)_____

Type of pain: *Please circle* **Sharp** **Dull** **Throbbing** **Burning**
Numbness **Cramping** **Other**

Frequency of pain: *Please circle* **Constant** **Irregular**

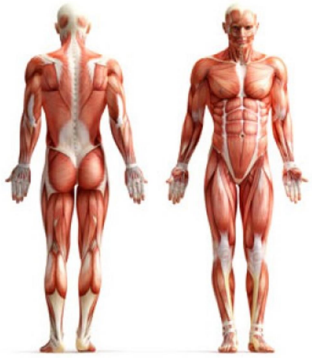
Does it interfere with: *Please Circle* **Work** **Sleep** **Daily Routine** **Recreation**

Activities that are most painful:_____

Activities that the pain stops you from doing:_____

Please mark on the picture where you have pain, numbness or tingling.

Drs. Notes



Health History

Have you received other types of care for your condition?_____

Have you received any previous chiropractic care: **Y** **N**

Chiropractors Name _____Address:_____

Date of last spinal examination? (X-ray, MRI, CT or bone scan)_____

Surgeries/Ops:_____

Please tick the following conditions you currently have:

□ Arthritis	□ Allergy	□ Anxiety	□ Asthma
□ Back Troubles	□ Bursitis	□ Cancer	□ Constipation
□ Diabetes	□ Diarrhea	□ Disc Problem	□ Dizziness
□ Emphysema	□ Epilepsy	□ Gall Bladder Problems	□ Headaches
□ Heart Trouble	□ High Blood Pressure	□ Insomnia	□ Irregular Periods
□ Kidney Trouble	□ Liver Trouble	□ Menstrual Cramps	□ Migraines
□ Neuralgia	□ Neuritis	□ Pinched Nerve	□ Ringing in ears
□ Scoliosis	□ Sinus Trouble	□ Stomach Issues	□ Thyroid Problems

Please tick the following conditions your Parents may have had or currently have:

□ Arthritis	□ Anxiety	□ Asthma	□ Back Troubles
□ Bursitis	□ Cancer	□ Constipation	□ Diabetes
□ Disc Problem	□ Emphysema	□ Epilepsy	□ Headaches
□ Heart Trouble	□ High Blood Pressure	□ Insomnia	□ Kidney Trouble
□ Liver Trouble	□ Migraines	□ Neuralgia	□ Neuritis
□ Pinched Nerve	□ Scoliosis	□ Sinus Trouble	□ Stomach Issues

Medications/Vitamins/Supplements: Please list any of the following you are currently taking

Medications: _____

Vitamins: _____

Supplements: _____

For women only:

Are you pregnant? Yes/no/not sure Due Date:_____

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, sports etc.)
    a. _____
    b. _____
    c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
    a. _____
    b. _____
    c. _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
    a. _____
    b. _____
    c. _____

On a scale of 1-10 please grade your present levels of stress

(Including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health?

Excellent □	Good □	Fair □	Poor □	Getting better □	Getting worse □

How do you grade your emotional/mental health?

Excellent □	Good □	Fair □	Poor □	Getting better □	Getting worse □

I hereby authorize the Chiropractic Doctor to perform any necessary diagnostic procedures, to fully evaluate my condition for the presence of vertebral subluxation.

Patient Signature:_____ Date:_____