CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Legal Name: _____

Preferred Name: _____

Date: _____ Sex at birth: Male / Female

Date of Birth:_____ Age: _____

Relationship Status: Single / Married /Divorced / Partner/ Widowed

Occupation: _____Employer: _____

Retired / Stay at Home spouse or parent / Permanent Disability

Address: _____

City:_____ State:_____ Zip: _____

Phone Number: Home/Cell _____

Other: _____ Work / Cell / Home

Email Address: _____

@gmail.com / @yahoo.com / @hotmail.com / @_____.com

REFERRAL INFORMATION

Whom May We Thank for Referring You?

_____

If this is a healthcare provider, do we have your permission to share information with them about you? Yes / No

Phone number of office: _____

INSURANCE / PAYMENT INFORMATION

SELF PAY: ____ COST SHARING PLAN: _____

INSURANCE COMPANY: _____

ID #: _____ GROUP#: _____

POLICY HOLDER: _____

RELATIONSHIP TO YOU: _____

SECONDARY POLICY: _____

ID #: _____ GROUP#: _____

Patient/Guardian understands that, ultimately, the patient/guardian is responsible for all charges. We are happy to assist and file insurance claims for our patients. Patient/guardian authorizes release of all information regarding the records if needed. _____ Initials

PATIENT HOUSEHOLD INFORMATION

Spouse/Partner name: _____/ None

Contact #: _____

Is the person above your EMERGENCY CONTACT? Y / N

If not, then list Emergency Contact : _____

Contact's phone #: _____

Do you give us Permission to Share Information about you with them? Spouse/Partner? Y / N Emergency Contact? Y / N

**These people will only be contacted in the case of an emergency*

Are there any children living in the Home? Yes / No

How many? _____ Ages? _____

Do you have Minor children that reside outside the household?

Yes/ No How Many? _____ Ages? _____

PATIENT CONDITION

PLEASE CHECK IF YOU ARE HERE FOR WELLNESS CARE _____

REASON FOR VISIT: _____

Is this condition due to an accident? Y / N

When did your condition appear? _____

Is this a flare up of a chronic condition? Yes / No

Is your condition getting: Better / Same / Worse

IF this condition is causing Pain:

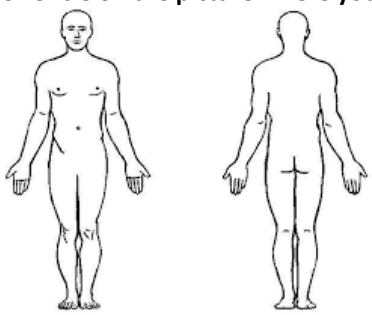
Rate the severity: (0 least to 10 worst) _____

Type of Pain: sharp / achy(dull) / numbness

Other: _____

Does it interfere with: Work / Sleep / Daily Routine

Put an (X) or Circle on the picture where your condition is:



HEALTH HISTORY

Previous Chiropractic Care? No _____ Yes _____ If yes, when was your last adjustment? _____

What were you treated for? _____ Wellness Care? _____ Were you Satisfied With Your Care? Yes / No

Any Concerns or Information You Wish to Share with the Doctor? _____

Do You Have a Primary Care Physician? Yes / No If Yes, Name of Physician: _____

Have you had any x-rays or MRIs or other Imaging in the Last 2 Years? Yes / No If Yes: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS: (CHECK)

AIDS/HIV		ALCOHOL/DRUG DEPENDENCE		ALLERGIES		ANEMIA	
APPENDICITIS		ASTHMA		CANCER		CATARACTS	
CHICKEN POX		DIABETES TYPE 1 OR TYPE 2		EMPHYSEMA		EPILEPSY	
GLAUCOMA		GOITER		GOUT		HEART DISEASE	
HEPATITIS B OR C		HERNIA		HERNIATED DISK		HIGH BLOOD PRESSURE	
HIGH CHOLESTEROL		KIDNEY DISEASE		LIVER DISEASE		MEASLES/MUMPS	
OSTEOPOROSIS		PACEMAKER		PARKINSON'S		ALZHEIMER'S	
POLIO		PROSTATE PROBLEMS		STROKE		THYROID DISORDERS	
TUMORS/GROWTHS		ULCERS		STDs (Sexually Transmitted Diseases)			
TUBERCULOSIS		HEARING LOSS		FIBROMYALGIA		EATING DISORDERS	
HEADACHES: __X/MONTH		MIGRAINES: ___X /MONTH		OTHER:			
AUTOIMMUNE CONDITIONS:				PSYCHIATRIC CARE:			

VACCINATIONS: Last Tetanus (DTaP): Shingles: Flu: Covid: Other:

DO YOU WEAR CORRECTIVE LENSES OR CONTACTS? YES / NO DO YOU WEAR HEARING AIDS? YES / NO

EXERCISE	**WORK ACTIVITY**	**HABITS**
None / Moderate / Daily Which Activities? Yoga Running Walking Weight Lifting Other:	Sitting: _____ hrs/ day Standing: _____ hrs/day Labor- Light or Heavy _____hrs/day Other:	How much water do you drink in a day? _____cups Smoking: Yes/ No _____ packs/day Alcohol: _____ drinks/week Caffeine: _____cups/day High Stress? Yes / No Reason? _____

For Women Only: Begin Date of Last Menstrual Cycle: _____ If Menopause: Year? _____

Are you pregnant? Yes No IF YES, THEN PLEASE FILL OUT PREGNANCY QUESTIONNAIRE IF 20+ WEEKS GESTATION

INJURIES AND SURGERIES

DESCRIPTION OF INCIDENT	DATE	ANY CARE RECEIVED?
MAJOR FALLS:		
CAR ACCIDENTS/BIKE ACCIDENTS (EVEN IF MINOR):		
BROKEN BONES OR DISLOCATIONS:		
SURGERIES:		
CANCER (FOR YOU PERSONALLY):		

MEDICATIONS/VITAMINS/HERBS/MINERALS

PLEASE LIST ALL Rx MEDICATIONS, VITAMINS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING: _____

_____

_____

CURRENTLY NOT TAKING ANY: _____

I HEREBY ATTEST THAT ALL THE INFORMATION I HAVE GIVEN IS TRUE TO THE BEST OF MY KNOWLEDGE

PATIENT SIGNATURE: DATE: