Patient Registration: *Please complete entire form.* **Today's Date**________________

Name:______________________________ **Prefer to be called**________________

Date of Birth:____________ **Gender:** M F **Marital Status:** S M D W Sep **SSN:**______________

Address:______________________ **City**______________ **State**_____ **Zip**_______

Home #______________ **Cell #**______________ **Email**__________@__________

Student Status: Non-student FT PT **Employment:** FT PT Unemployed Military Retired Self Employed

Employer:______________________ **Occupation:**______________________

Insurance #1:______________________ **Insurance #2 :**______________________

Chief Complaint:____

When this began: __________ **How it began:** Work Auto Other ____________________

Have you had anything similar to this before? No Yes, Explain____________________

Other treatments for this problem: [illegible] Medications Injections Surgery PT Massage None ________

The pain is: Sharp Dull Aches Burns Shoots Throbs Stabs Sore Stiff Other________________

How often is it present? Constant-100% of time Frequent-75% Intermittent-50% Occassional-25%

Does it radiate or shoot to other areas of the body? Rt arm Lt arm Rt leg Lt leg *Pain* *Numb* *Tingle* None Other______

Pain is aggravated by? Sitting Standing Laying Sleeping Walking Bending Lifting Twisting Overuse __________

Pain is reduced by? Heat Ice Rest Stretching Meds __________________________

This problem affects my ability to: Work School Sleep Be active Daily activities Recreation Childcare ________

Health History

Allergies: None ____

Current Medications/Supplements: None ______________________________

____

Past Surgeries/Hospitalizations: None ______________________________

____

Past Accidents/Trauma: None __________________________________

____

Family History

(family = parent, sibling)

	Me	Family		Me	Family	
Arthritis	( )	( )	Heart Disease	( )	( )	
Asthma	( )	( )	High Blood Pressure	( )	( )	
Bleeding Disorder	( )	( )	Seizures/Epilepsy	( )	( )	None Apply ( )
Cancer	( )	( )	Stroke	( )	( )	
Diabetes	( )	( )	Tuberculosis	( )	( )	

Social History

Do you smoke? Never used Former user Current user **# Packs per day**_______

Do you use smokeless tobacco? Never used Former user Current user **Explain**__________

Do you drink alcohol? No Yes, ______________________________

Do you use recreational drugs? No Yes, __________________________

What is your exercise routine? None __________________________

REVIEW OF SYSTEMS

Name ______________________________ **Date** ____________

Are you *currently* experiencing any of these symptoms? ***(Answer each section)***

General: *(constitutional)*
- ☐ Recent Weight Change
- ☐ Fever
- ☐ Fatigue
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Low Back Pain/Stiffness
- ☐ Mid Back Pain/Stiffness
- ☐ Neck Pain/Stiffness
- ☐ Arm Problems ____________
- ☐ Leg Problems ____________
- ☐ Painful Joints
- ☐ Stiff/Swollen Joints
- ☐ Sore/Weak Muscles or Joints
- ☐ Muscle Spasms/Cramps
- ☐ Broken Bones ____________
- ☐ Other: ____________
- ☐ *None in this Category*

Neurological:
- ☐ Numbness or tingling sensations
- ☐ Loss of Feeling
- ☐ Dizziness or light headed
- ☐ Frequent or Recurrent Headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Other: ____________
- ☐ *None in this Category*

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: ____________
- ☐ *None in this Category*

Genitourinary:
- ☐ Sexual Difficulty
- ☐ Kidney Stones
- ☐ Burning/Painful Urination
- ☐ Change in force/strain w Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Other: ____________
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool
- ☐ Change in Bowel Movements
- ☐ Painful Bowel Movements
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: ____________
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains
- ☐ Rapid or Heartbeat changes
- ☐ Blood Pressure Problems
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Heart Problems
- ☐ Other: ____________
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Coughing Blood
- ☐ Asthma or Wheezing
- ☐ Lung Problems
- ☐ Other: ____________
- ☐ *None in this Category*

Eyes and Vision:
- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other: ____________
- ☐ *None in this Category*

Ears, Nose and Throat:
- ☐ Bleeding gums / mouth sores
- ☐ Bad Breath or bad taste
- ☐ Dental Problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Sinus / Allergy problems
- ☐ Nose Bleeds
- ☐ Hearing Loss
- ☐ Other: ____________
- __ *None in this Category*

Endocrine, Hematologic, and Lymphatic:
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive Thirst or urination
- ☐ Cold Extremities
- ☐ Heat or Cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problem
- ☐ Swollen Glands
- ☐ Anemia
- ☐ Easily Bruise or Bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other: ____________
- ☐ *None in this Category*

Skin and Breasts:
- ☐ Rash or Itching
- ☐ Change in Skin Color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change of appearance of a mole
- ☐ Breast Pain
- ☐ Breast Lump
- ☐ Breast Discharge
- ☐ Other: ____________
- ☐ *None in this Category*

Women Only:

Are currently you pregnant?
- ☐ **Yes -** ***Due Date*** ___/___/___
- ☐ **No -** ***Last Menstrual Period*** ___/___/___

- ☐ Infertility
- ☐ Painful or Irregular periods
- ☐ Vaginal Discharge
- ☐ Other: ____________
- ☐ *None in this Category*

 # Pregnancies: ____________
 # Children: ____________

Comments: ______________________________

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I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient/Guardian Signature ______________________________ Date ____________