CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Patient _____

Address _____

City_____ State_____ Zip _____

E-mail _____

Sex: ❑ Male ❑ Female Age_____ Birthdate _____

Height _____ Weight_____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Number of Children _____

Patient SS# _____

Occupation _____

Employer _____

Employer Phone _____

Spouse's Name _____

Birthdate_____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you?_____

_____

2 INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. 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 secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

3 PHONE NUMBERS

Home _____ Work_____ Ext. _____

Cell Phone_____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship_____

Home Phone _____ Work Phone _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date_____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

5 PATIENT CONDITION

Have you ever had Chiropractic care before? _____ If yes, doctor name: _____ Date of last visit _____

Reason for your visit (neck pain, mid back pain, low back pain, etc.), health problems, symptoms, and/or complaints. Please list in order of severity. Rate the severity of your pain on a scale of 1 (least pain) - 10 (severe pain):

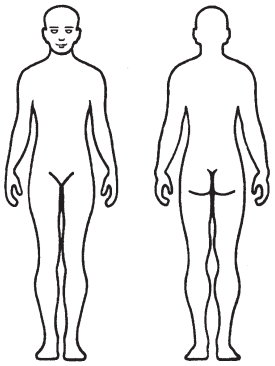
1. _____ For how long? _____ Pain Level:_____ Cause: _____

2. _____ For how long? _____ Pain Level:_____ Cause: _____

3. _____ For how long? _____ Pain Level:_____ Cause: _____

4. _____ For how long? _____ Pain Level:_____ Cause: _____

5 PATIENT CONDITION CONTINUED



Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

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

What is the name of your family physician?_____ **What city are they located in?** _____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing.) In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. 0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) _____

2. RECREATION: hobbies, sports, and other similar leisure time activities. _____

3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theatre, concerts, dining out, and other social functions. _____

4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____

5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____

6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. _____

Name_____ **Date**_____

6 SYMPTOM SURVEY

1. GENERAL SYMPTOMS: (Circle as many as apply)

A) Nervousness B) Irritability C) Fatigue D) Depression
E) Loss of Sleep F) Tension G) PMS H) Jaw Pain

2. HEAD: (Circle as many as apply)

A) Headache 1) Mild 2) Moderate 3) Severe
How often? (1 2 3 4 5 6) per (Day / Week / Month)
Are they? 1) Sharp 2) Dull
Are they? 1) Constant 2) Intermittent
Where located? 1) Back of Head 2) Forehead
3) Temples 4) Right Side
5) Left Side 6) Behind Eyes
B) Light Headed C) Memory Loss D) Fainting
E) Blurred Vision F) Double Vision G) Sensitivity to Light
H) Loss of Balance I) Hearing Loss J) Ringing in Ears

3. NECK: (Circle as many as apply)

A) Pain 1) Left 2) Right 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
Pain increased by: 1) Forward movement
2) Backward movement
3) Rotate head left 4) Rotate head right
5) Bend neck left 6) Bend neck right
B) Stiffness C) Muscle Spasm D) Grinding/Grating sound

4. SHOULDER: (Circle as many as apply)

A) Pain in Joint 1) Left 2) Right 3) Both
B) Pain across Shoulder 1) Left 2) Right 3) Both
C) Limitation of Movement 1) Left 2) Right 3) Both
D) Tension 1) Left 2) Right 3) Both

5. ARMS: (Circle as many as apply)

A) Pain in Upper Arm 1) Left 2) Right 3) Both
B) Pain in Elbow 1) Left 2) Right 3) Both
C) Pain in Forearm 1) Left 2) Right 3) Both
D) Pins & Needles (Arm) 1) Left 2) Right 3) Both
E) Pins & Needles (Forearm) 1) Left 2) Right 3) Both
F) Numbness in Arm 1) Left 2) Right 3) Both
G) Numbness in Forearm 1) Left 2) Right 3) Back

6. HANDS: (Circle as many as apply)

A) Pain in Wrist 1) Left 2) Right 3) Both
B) Pain in Hand 1) Left 2) Right 3) Both
C) Pins & Needles (Hand) 1) Left 2) Right 3) Both
D) Numbness 1) Left 2) Right 3) Both

7. MIDBACK: (Circle as many as apply)

A) Pain 1) Left 2) Right 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
Pain Type 1) Sharp/Stabbing 2) Dull Ache
B) Muscle Spasm 1) Left 2) Right 3) Both

8. CHEST: (Circle as many as apply)

A) Deep Chest Pain 1) Left 2) Right 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
B) Pain around Ribs 1) Left 2) Right 3) Both
C) Shortness of Breath
D) Irregular Heartbeat

9. ABDOMINAL SYMPTOMS: (Circle as many as apply)

A) Pain 1) Mild 2) Moderate 3) Severe
B) Nervous Stomach C) Nausea D) Gas
E) Constipation F) Diarrhea G) Heartburn
H) Indigestion I) Loss of Appetite

10. LOWBACK: (Circle as many as apply)

A) Upper Lumbar Pain 1) Left 2) Right 3) Both
B) Lower Lumbar Pain 1) Left 2) Right 3) Both
C) Sacro-Iliac Pain 1) Left 2) Right 3) Both
Lowback Pain 1) Mild 2) Moderate 3) Severe
D) Muscle Spasm 1) Left 2) Right 3) Both

11. HIPS AND LEGS: (Circle as many as apply)

A) Pain in Buttocks 1) Left 2) Right 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
B) Pain in Hip Joint 1) Left 2) Right 3) Both
Pain Level 1) Mild 2) Moderate 3) Severe
C) Pain down Leg 1) Left 2) Right 3) Both
Location 1) Front 2) Back 3) Side
Pain Radiates to 1) Knee 2) Calf 3) Foot
D) Numbness Down Leg 1) Left 2) Right 3) Both
Location 1) Front 2) Back 3) Side
E) Pins & Needles (Legs) 1) Left 2) Right 3) Both
Location 1) Front 2) Back 3) Side
F) Knee Pain Leg 1) Left 2) Right 3) Both
G) Leg Cramps 1) Left 2) Right 3) Both

12. FEET: (Circle as many as apply)

A) Ankle Pain 1) Left 2) Right 3) Both
B) Swollen Ankle 1) Left 2) Right 3) Both
C) Foot Pain 1) Left 2) Right 3) Both
D) Numbness of Feet 1) Left 2) Right 3) Both
E) Swollen Feet 1) Left 2) Right 3) Both
F) Cramps 1) Left 2) Right 3) Both

7 MEDICATIONS

_____

_____

ALLERGIES

_____

_____

Name_____ **Date**_____

8 REVIEW OF SYSTEMS

Discover Wellness Center focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check the box beside any condition that you've **Had** or currently **Have** and initial to the right.

Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		
❑	❑	Osteoporosis	❑	❑	Arthritis	❑	❑	Scoliosis	❑	❑	Broken Bones	❑ None
❑	❑	Back Problems	❑	❑	Poor Posture	❑	❑	Neck Pain				

Neurological

Had	Have		Had	Have		Had	Have		
❑	❑	Anxiety	❑	❑	Depression	❑	❑	Pins & Needles	❑ None
❑	❑	Headache	❑	❑	Dizziness	❑	❑	Numbness	

Cardiovascular System

Had	Have		Had	Have		Had	Have		
❑	❑	High Blood Pressure	❑	❑	High Cholesterol	❑	❑	Stroke	❑ None
❑	❑	Low Blood Pressure	❑	❑	Chest Pain	❑	❑	Heart Disease	

Respiratory System

Had	Have		Had	Have		Had	Have		
❑	❑	Asthma	❑	❑	Emphysema	❑	❑	Shortness of Breath	❑ None
❑	❑	Apnea	❑	❑	Hay Fever	❑	❑	Pneumonia	

Digestive System

Had	Have		Had	Have		Had	Have		
❑	❑	Anorexia/Bulemia	❑	❑	Food Sensitivities	❑	❑	Constipation	❑ None
❑	❑	Ulcer	❑	❑	Heartburn	❑	❑	Diarrhea	

Sensory System

Had	Have		Had	Have		
❑	❑	Blurred Vision	❑	❑	Hearing Loss	❑ None
❑	❑	Ringing in Ears	❑	❑	Chronic Ear Infections	

Integumentary System

Had	Have		Had	Have		Had	Have		
❑	❑	Skin Cancer	❑	❑	Eczema	❑	❑	Hair Loss	❑ None
❑	❑	Psorasis	❑	❑	Acne	❑	❑	Rash	

Endocrine System

Had	Have		Had	Have		Had	Have		
❑	❑	Thyroid Issues	❑	❑	Immune Disorders	❑	❑	Hypoglycemia	❑ None
❑	❑	Frequent Infection	❑	❑	Diabetes				

Genitourinary System

Had	Have		Had	Have		Had	Have	
❑	❑	Kidney Stones	❑	❑	Bedwetting	❑	❑	PMS Symptoms
❑	❑	Infertility	❑	❑	Prostate Issues			

Constitutional System

Had	Have		Had	Have		Had	Have		Had	Have	
❑	❑	Sudden Weight Gain	❑	❑	Poor Appetite	❑	❑	Fainting	❑	❑	Low Libido
❑	❑	Sudden Weight Loss	❑	❑	Fatigue	❑	❑	Weakness			

Are there any other injuries/illnesses that you have had or have now that we have not discussed (i.e. cancer)?

_____

_____

Family History

	Hearth Disease	Arthritis	Cancer	Diabetes	Other
Mother's Side	_____	_____	_____	_____	_____
Father's Side	_____	_____	_____	_____	_____

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Name_____ **Date**_____