REGISTRATION

Date_____ Home Phone_____

Patient_____
Last Name First Name Initial

Street Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #_____ Driver's License #_____

Insured's Name_____
Last Name First Name Initial

Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other Condition Related to ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER

Company Name_____ Occupation_____

Address_____ Phone_____

City_____ State_____ Zip_____

SPOUSE

Name_____
Last Name First Name Initial

Birthdate_____ Social Security #_____

Employer Name_____ Occupation_____

Address_____ Phone_____

City_____ State_____ Zip_____

PATIENT INSURANCE INFORMATION

Please ✓ any and all insurance coverage you or your spouse has applicable in this case.

☐ MEDICARE ☐ BLUE SHIELD ☐ AUTO ACCIDENT
☐ MEDICAID ☐ MAJOR MEDICAL ☐ UNION PLAN
☐ BLUE CROSS ☐ WORKER'S COMPENSATION ☐ OTHER

BCBS I.D. # _____

MEDICARE/MEDICAID I.D. # _____

MAJOR MEDICAL OR AUTO INSURANCE Date of accident_____

Insurance Company Name_____ Adjuster_____

Address/Phone_____ Claim #_____

Policy #_____ Effective Date_____

SPOUSE CO-INSURANCE INFORMATION

MAJOR MEDICAL ONLY
Insurance Company Name_____

Address/Phone_____

Policy #_____ Effective Date_____

MEDICAL AND LEGAL INFORMATION

Referred by_____

Present Complaint _____

Known Medical Problems_____

_____

Attorney_____

Address_____

_____

Phone_____

Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____

Person to contact in emergency (Name and Phone #)_____

PATIENT AGREEMENT

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with_____
Name of Insurance Company

and assign directly to Dr._____ all medical 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 my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

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THE STRESS TEST

PATIENT:_____ DATE:_____

The following three areas of stress can cause a misaligned vertebra (subluxation). Do you recognize any of these stresses? Please circle when you experienced these stresses: C (child), T (teenager), A (adult), or N (not at all).

I. PHYSICAL STRESS:					EXPLAIN
Birth Traumas (as a mother or child)	C	T	A	N	_____
Slips/Falls	C	T	A	N	_____
Car Accidents	C	T	A	N	_____
Sports Injuries	C	T	A	N	_____
Physical Abuse	C	T	A	N	_____
Work Injuries	C	T	A	N	_____
Poor Posture	C	T	A	N	_____
Sitting on your wallet for years	C	T	A	N	_____
Sleeping Position - Stomach	C	T	A	N	_____
Extensive Computer Work	C	T	A	N	_____
Carrying Heavy Purse/Bookbag/Child	C	T	A	N	_____
Repetitive Lifting/Bending	C	T	A	N	_____
Driving for Many Hours	C	T	A	N	_____
Continuous Hours Sitting/Standing	C	T	A	N	_____
Bone Fracture/Surgery	C	T	A	N	_____

II. EMOTIONAL STRESS:					EXPLAIN
Relationships	C	T	A	N	_____
Career	C	T	A	N	_____
Children	C	T	A	N	_____
Money	C	T	A	N	_____
Fast-Paced Life	C	T	A	N	_____
Hold in Feelings	C	T	A	N	_____
Quick Tempered	C	T	A	N	_____
Verbal Abuse	C	T	A	N	_____
Perfectionist	C	T	A	N	_____
Procrastinator	C	T	A	N	_____
Sickness or Loss of Loved One	C	T	A	N	_____

III. CHEMICAL STRESS:					EXPLAIN
Environment (i.e. pollution)	C	T	A	N	_____
Smoker - Amount?	C	T	A	N	_____
Second-hand Smoke	C	T	A	N	_____
Poor Diet	C	T	A	N	_____
Caffeine - Amount?	C	T	A	N	_____
Excessive Sugar	C	T	A	N	_____
Artificial Sweeteners	C	T	A	N	_____
Prescription Drugs	C	T	A	N	_____
Over-The-Counter Drugs *(Example: Tylenol; Motrin)*	C	T	A	N	_____

IV. What do you feel is your primary stress? _____

_____

_____

HISTORY FORM
page two

History of the Current Problem

When did the problem begin? _____
Does it come & go or is it constant? _____
Anything relieve it? _____
Anything aggravate it? _____
Have you had this problem before? If so, when, how long did it last, and what treatments did you receive? _____
If there is pain associated with the problem.....
Would you characterize the pain as deep, achey, dull, throbbing, or sharp? ____
Does the pain stay local or does it go up or down the body? _____
On a scale of 1-10, 10 being the most severe, rate the pain. _____
Is the pain getting better or worse? _____

Past History

List the dates of any surgeries. + Type of Surgery. _____
List the dates of any hospitalizations. + Reason for hospitalization. _____
List the dates and severity of any automobile accidents. Include fender benders. _____
List any sports you play or have played and any injuries which have occurred. _____
List the dates & injuries from any falls (trees, houses, stairs). _____
List the dates of any major illnesses. _____
Females, list any problems with PMS or menstrual cycle. _____
What was your birth like? _____

Family History

List your siblings and their ages & if they have any health problems. _____
What is the health of your parents? _____

Medical/Social History

How many times in your whole life have you taken antibiotics? _____
Have you taken them recently? _____
Have you taken acidophilus? _____
Females, are you taking oral contraceptives? If yes, for how long? _____
Females, have you ever been pregnant? _____

Do you smoke? If yes, how much & for how long. _____
If you are an ex-smoker, when did you quit & how long did you smoke? _____
Do you drink? If yes, what do you drink, how much, & how often? _____
If you are sober, when did you quit & for how long did you drink? _____
Do you do any recreational drugs? If yes, what do you use, how much, how often, & for how long? _____
If you used to use drugs, when did you quit & what did you use? _____

What are your hobbies? _____
_____

What kind of regular exercise do you do? _____
How often? _____

Diet History

List your typical breakfast. _____
_____
List your typical lunch. _____
_____
List your typical dinner. _____
_____
List any snacks you typically have. _____
_____

How much caffeinated coffee do you drink? _____ Tea? _____
Decaf coffee? _____ Herbal Tea? _____ Water? _____
Diet Soda? (list kind) _____ Regular Soda? (list kind) _____

Please use the space below to elaborate on your problem or give any information which might have been missed in the above questionnaire.

_____
_____
_____
_____
_____

CHIROPRACTIC HEALTH QUESTIONNAIRE

Date_____

Patient name_____ Birthdate_____

Reason for visit_____

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

If yes, by ☐ Physician ☐ Doctor of Chiropractic ☐ Physical Therapist ☐ Osteopath ☐ Other_____

What did they do and/or recommend?_____

When did your symptoms appear?_____ Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

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 ☐ 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 prescription drugs_____ Please list all medication in the space at bottom of page.

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_____

Sleep_____ hrs/night Do you sleep on your ☐ Back ☐ Side ☐ Stomach Non-job exercise_____ hrs/wk

Age of mattress_____ or waterbed_____ Is your bed comfortable? ☐ No ☐ Yes

What kind of pillow do you use? ☐ Thick ☐ Medium ☐ Thin ☐ None ☐ Support

Do you wear ☐ Heel lifts ☐ Shoe lifts ☐ Arch supports ☐ Orthotics, describe_____

CONDITIONS Check (✓) conditions 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 problems
☐ 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	☐ Other_____
☐ Chicken pox	☐ Kidney disease	☐ Rheumatoid arthritis	_____

MEDICATIONS List medications you are currently taking	**VITAMINS/HERBS/MINERALS**
Allergies_____	
Pharmacy Name_____ Phone_____	

GENERAL SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Bruise easily
- ☐ Chills
- ☐ Dental problems
- ☐ Depression
- ☐ Difficulty sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ 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
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – flashes
- ☐ Vision – halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in 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 you pregnant?_____

Number of children_____

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

NECK
- ☐ Pain in neck
- ☐ Neck stiffness
- ☐ Neck weakness
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding/popping sounds in neck

SHOULDERS

	Right	Left
☐ Pain in shoulder joint	☐ R	☐ L
☐ Pain across shoulders		
☐ Can't raise arm	☐ R	☐ L
☐ Above shoulder level		
☐ Over head		
☐ Tension in shoulders		
☐ Pinched nerve in shoulder	☐ R	☐ L

MID-BACK
- ☐ Mid-back pain
- ☐ Mid-back stiffness
- ☐ Pain between shoulder blades
- ☐ Pain from front to back
- ☐ Muscle spasms in mid-back

ARMS & HANDS

	Right	Left
☐ Pain in upper arm	☐ R	☐ L
☐ Pain in elbow	☐ R	☐ L
☐ Pain in forearm	☐ R	☐ L
☐ Pain in hand	☐ R	☐ L
☐ Pain in fingers	☐ R	☐ L
☐ Pins & needles in arm	☐ R	☐ L
☐ Pins & needles in fingers	☐ R	☐ L
☐ Numbness in arm	☐ R	☐ L
☐ Numbness in fingers	☐ R	☐ L
☐ Weakness of arm	☐ R	☐ L
☐ Weakness of hand	☐ R	☐ L
☐ Hands cold	☐ R	☐ L

LOW BACK
- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back weakness
- ☐ Pinched nerve in low back
- ☐ Low back feels out of place
- ☐ Muscle spasms in low back

HIPS, LEGS & FEET

	Right	Left
☐ Pain in buttocks	☐ R	☐ L
☐ Pain in hip joint	☐ R	☐ L
☐ Pain down leg	☐ R	☐ L
☐ Pain in knee	☐ R	☐ L
☐ Pain in ankle	☐ R	☐ L
☐ Pain in foot	☐ R	☐ L
☐ Weakness of leg	☐ R	☐ L
☐ Weakness of knee	☐ R	☐ L
☐ Leg cramps	☐ R	☐ L

OTHER SYMPTOMS

_____

_____

_____

_____

_____

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/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient Signature Date

Reviewed by_____ _____

Doctor Date

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