

# W e l c o m e

**Patient Registration:** Please print and fill out completely and bring to your first visit

## Patient Information

Date \_\_\_\_\_  
Name \_\_\_\_\_  
Prefer to be called \_\_\_\_\_  
Address \_\_\_\_\_  
City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: (h) \_\_\_\_\_ (cell) \_\_\_\_\_  
e-mail \_\_\_\_\_  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_  Male  Female  
 Single  Married  Divorced  Separated  Widowed  
Spouse \_\_\_\_\_  
Do you have Children  Yes  No How Many? \_\_\_\_\_  
Referred to this office by \_\_\_\_\_

## Employment Information

Employer \_\_\_\_\_  
Address \_\_\_\_\_  
City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Ext \_\_\_\_\_  
Occupation \_\_\_\_\_

## Insurance Information

Ins Company \_\_\_\_\_  
Type:  Health  Auto  Worker's Comp  Medicare  
\*Please bring your insurance card and ID to your first visit  
 I hereby authorize assignment of insurance benefits  
directly to provider for services rendered

## Emergency Contact

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Phone \_\_\_\_\_  
Who is your medical Doctor? \_\_\_\_\_  
Office location \_\_\_\_\_

## Account Information

Person Responsible for Account \_\_\_\_\_  
Relationship \_\_\_\_\_  
Billing address if different from patient address  
\_\_\_\_\_  
City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_

## Patient Condition

Reason for visit \_\_\_\_\_ When did your symptoms appear? \_\_\_\_\_  
Is this due to an accident?  Yes  No If Yes:  Auto  Work  Sports  Other \_\_\_\_\_  
Have you had this condition before?  No  Yes when \_\_\_\_\_  
Describe your complaint and its location \_\_\_\_\_  
Is it getting worse?  Yes  No  Constant  Comes and goes  Chronic  
Rate your pain: 0 = no pain 10 = unbearable 0 1 2 3 4 5 6 7 8 9 10  
Does it interfere with daily activities?  No  Yes explain \_\_\_\_\_  
Do you have  Numbness  Tingling Location \_\_\_\_\_  
What have you tried to relieve the problem(s)? \_\_\_\_\_  
Have you seen anyone else for this condition?  No  Yes Who? \_\_\_\_\_  
Have you ever been treated by a chiropractor?  No  Yes Dr's Name and location \_\_\_\_\_

## Patient Health History

Are you currently taking any of the following? (Please list and give reason for taking)

Prescription medications \_\_\_\_\_

Over the counter medications \_\_\_\_\_

Vitamins/supplements \_\_\_\_\_

Do you currently have or have had any of the following diseases/medical condition? Check  Yes or No

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart attack            | <input type="checkbox"/> Y <input type="checkbox"/> N Allergies          | <input type="checkbox"/> Y <input type="checkbox"/> N Seizures/Epilepsy       |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital heart defect | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble      | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis               |
| <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure     | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney problems    | <input type="checkbox"/> Y <input type="checkbox"/> N Fibromyalgia            |
| <input type="checkbox"/> Y <input type="checkbox"/> N Low blood pressure      | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease   | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatoid arthritis    |
| <input type="checkbox"/> Y <input type="checkbox"/> N Headaches               | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers/Colitis     | <input type="checkbox"/> Y <input type="checkbox"/> N Pneumonia               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart surgery           | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes           | <input type="checkbox"/> Y <input type="checkbox"/> N Hearing trouble         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker               | <input type="checkbox"/> Y <input type="checkbox"/> N HIV/AIDS           | <input type="checkbox"/> Y <input type="checkbox"/> N Digestive problems      |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dizziness/Fainting      | <input type="checkbox"/> Y <input type="checkbox"/> N Miscarriage        | <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia                  | <input type="checkbox"/> Y <input type="checkbox"/> N Vision problems    | <input type="checkbox"/> Y <input type="checkbox"/> N Pinched nerve           |
| <input type="checkbox"/> Y <input type="checkbox"/> N Shingles                | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid problems   | <input type="checkbox"/> Y <input type="checkbox"/> N Fractures               |
| <input type="checkbox"/> Y <input type="checkbox"/> N Prostate trouble        | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis          | <input type="checkbox"/> Y <input type="checkbox"/> N Implants _____          |
| <input type="checkbox"/> Y <input type="checkbox"/> N Appendicitis            | <input type="checkbox"/> Y <input type="checkbox"/> N Gout               | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer/tumors *         |
| <input type="checkbox"/> Y <input type="checkbox"/> N Low back pain           | <input type="checkbox"/> Y <input type="checkbox"/> N Polio              | * Type _____  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Neck pain               | <input type="checkbox"/> Y <input type="checkbox"/> N Chicken Pox        | Date of diagnosis _____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Stroke                  | <input type="checkbox"/> Y <input type="checkbox"/> N Scoliosis          | Treatment _____   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing    | <input type="checkbox"/> Y <input type="checkbox"/> N Mental illness     | Current status _____  |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema               | <input type="checkbox"/> Y <input type="checkbox"/> N Multiple sclerosis |   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma                  | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis       |   |

Please list any other serious medical condition(s) you have ever had \_\_\_\_\_

List any surgeries/treatment/hospitalizations with dates \_\_\_\_\_

List any past serious accidents/injuries/broken bones/dislocations with dates \_\_\_\_\_

Family health history \_\_\_\_\_

Do you participate in any physical activity? \_\_\_\_\_

Do you smoke?  No  Yes How much \_\_\_\_\_ How long \_\_\_\_\_ Do you drink alcohol?  No  Yes \_\_\_\_\_/week

Do you drink coffee/caffeine drinks?  No  Yes Cups/day \_\_\_\_\_

Do you have high stress levels?  No  Yes reason \_\_\_\_\_

Do you wear  Heel lifts  arch supports/orthotics Do you have foot pain?  No  Yes

Does your job require  Sitting \_\_\_\_\_ hrs  Standing \_\_\_\_\_ hrs  Lifting \_\_\_\_\_ lbs

Hours of sleep per night \_\_\_\_\_ Quality  Good  Fair  Poor

For women:

Are you pregnant?  No  Yes \_\_\_\_\_ weeks Due date \_\_\_\_\_ Nursing  No  Yes

Are you on birth control?  No  Yes \_\_\_\_\_

**I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.**

Patient / Guardian signature \_\_\_\_\_ Date \_\_\_\_\_