Patient Registration & Examination

Please Print. All information will be kept confidential.

Patient Information

Last Name	First,	Middle	Today's Date	Case No.

Address	City	State	Zip

Social Security	Age	Birth Date	Sex	Marital Status	No. of Children	Home Phone

Employer	Address	Business Phone

Occupation	Driver's License No.	State	Expiration Date

Who Referred you to us	Address

In case of emergency notify	Relationship	Phone

Family Doctor	May we contact him/her about your health ☐ Yes ☐ no	Phone

Person responsible for this account	Address	Phone

Name of charge card (if used)	Number	Expiration Date

If medical assistance, your number	If medicare, your number

Do you have medical insurance ☐ Yes ☐ No	Insurance Company Name	Policy No.	Phone	
Is your policy connected with your union ☐ Yes ☐ No	Union Name	Local	Group No.	

Social Security No. of person covered if other than patient

Chiropractic Problem *(Describe)*

How long have you had this condition	Is it getting worse ☐ Yes ☐ No	Does it bother your ☐ Work ☐ Sleep ☐ Other (specify)	
What seemed to be the initial cause			
Have you seen a chiropractor before ☐ Yes ☐ No (If yes, how long ago)	For what reason:		
Are you under the care of a physician ☐ Yes ☐ No (If yes, for what)			
Have you been hospitalized in the last 5 years ☐ Yes ☐ No	For major surgery ☐ Yes ☐ No	For serious injury ☐ Yes ☐ No	Have you had any mental or emotional disorders ☐ Yes ☐ No (If yes, when)

Drugs you now take: ☐ Birth Control Pills ☐ Tranquilizers ☐ Painkillers ☐ Others (specify)

Do you wear: ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports ☐ Negative Heels ☐ Platform Shoes

Age of your mattress: ☐ Comfortable ☐ Uncomfortable	Do you use a bedboard ☐ Yes ☐ No

How is most of your daytime spent? ☐ Standing ☐ Sitting ☐ Walking ☐ Other (specify)

Family Health Information

Some health conditions are the result of hereditary spinal weaknesses. Information about your immediate family members, brothers, sisters, parents, grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS

Please check the degree of all conditions you have or have had. We need your complete health report before we can be responsible for your case.

I = Irregular R = Regular S = Steady

Muscle/Joint

I	R	S	
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Low back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain, stiffness
☐	☐	☐	Pain between shoulders

General

I	R	S	
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness, depression
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors

Cardiovascular

I	R	S	
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heartbeat
☐	☐	☐	Slow heartbeat
☐	☐	☐	Swelling of ankles

Genitourinary

I	R	S	
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Lack of kidney control
☐	☐	☐	Kidney infection
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine

Eye, Ear, Nose and Throat

I	R	S	
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed Eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noise
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nose bleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

Gastrointestinal

I	R	S	
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Bloated abdomen
☐	☐	☐	Excessive hunger
☐	☐	☐	Gallbladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood

Skin

I	R	S	
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins

Pain or numbness in

I	R	S	
☐	☐	☐	Shoulders
☐	☐	☐	Arms
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful Tailbone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal curvature
☐	☐	☐	Swollen joints

Respiratory

I	R	S	
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing

Women only

I	R	S	
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps or backache
☐	☐	☐	Excess menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Lumps in breast
☐	☐	☐	Menopause
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

Are you pregnant ☐ Yes ☐ No

If yes, how long _____mo's.

Number of children _____

Check any of the following conditions you have or have had:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Chorea
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Herpes
- ☐ Influenza
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

Have you ever:

	Yes	No	If yes, briefly explain:
Had a broken bone?	☐	☐	
Been hospitalized?	☐	☐	
Had strains or sprains?	☐	☐	
Used a cane, crutch or other support?	☐	☐	
Been struck unconscious?	☐	☐	
Been hospitalized for other than surgery?	☐	☐	

Do you:

Take minerals, herbs or vitamins?	☐	☐
Think you need minerals, herbs or vitamins?	☐	☐
Have any drug allergy?	☐	☐

When did you last have:

	never	0–6 mo	6–18 mo	Longer
Spinal x-ray	☐	☐	☐	☐
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐

Please list any other health conditions you have been treated for, or surgery you have had in the last 10 years:

Habits

	None	Light	Mod.	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Water	☐	☐	☐	☐
Sugar & Products	☐	☐	☐	☐
Artificial sweeteners	☐	☐	☐	☐

Continued