Optimal Wellness Chiropractic Center, P.C.

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CHIROPRACTIC REGISTRATION AND HEALTH HISTORY

Date_____

Last name_____ First name _____ MI _____

Address _____

City_____ State _____ Zip _____

Phone (H) _____ (C) _____ (W) _____

Date of Birth _____ Social Security No. _____ Email _____

Status: _____Minor _____Single _____Married _____ Divorced

_____Separated _____ Widowed _____Partnered for ____ years

Patient Employer/School _____ Occupation _____

Employer Address _____ Phone _____

Spouse's Name _____ Employer _____ DOB _____

IN CASE OF EMERGE NCY, CONTACT:

Name _____ Relationship _____ Phone _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Primary insured's name _____ Relationship _____ DOB _____

Health Ins. Company _____ Member ID# _____

Group # _____ Insurance Co. Phone # _____

Is the patient covered by additional insurance? ____yes ____no

Insurance Co. _____ Member ID/Group #_____

PATIENT CONDITION

What brings you to our office? ____Wellness care _____ Acute/Chronic Pain _____ Auto accident/WC

Reason for visit today _____

Date symptoms first appeared _____ How? ____Gradual _____Sudden _____Progressive
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain ____Sharp ____Dull ____Ache ____ Burning ____Throbbing ____Tingling

Is the pain constant or does it come and go? _____

What activities/movements make the pain worse? _____

Have you been treated already for this condition? ___Y/N Type of treatment_____

Has this or something similar happened in the past? ___Y/N Explain_____

Have you ever been treated by a Doctor of Chiropractic? ____Y/N Dr's name_____

HEALTH HISTORY

Date of last physical exam _____ Are you pregnant? _____Y/N Due date _____

Are you taking birth control? ____Y/N Are you nursing? ___Y/N

Injuries/Surgeries that you have had (include dates)_____

_____

Fractures/Broken bones _____Y/N Dates _____ What body parts?_____

Any head injuries/concussions? _____Y/N Include dates_____ Lost consciousness? _____Y/N

Do you have or have had any of the following diseases, conditions or procedures?

Heart attack	Y	N	Heart/surgery pacemaker	Y	N	Artificial bones/joints/implants	Y	N
Heart defects			Hernia			Ulcers/Colitis		
AIDS/HIV			Herniated disc			Asthma/Emphysema		
Alcohol/drug abuse			High/Low blood pressure			Chemotherapy/Radiation		
Anemia			Kidney problems			Thyroid problems		
Breast lump			Liver problems			Tuberculosis		
Cancer			Osteoporosis			Vaginal/Yeast Infections		
Diabetes			Prostate problems			Arthritis		
Epilepsy/Seizures			Rheumatoid Arthritis			Rheumatic fever		
Glaucoma			Psychiatric care			Hepatitis		

CURRENT HEALTH

How would you describe your current health? ___ Excellent _____Good _____Fair _____Poor

How often do you exercise? _____None _____ Sometimes _____Often _____Daily

Do you smoke? _____Y/N Do you drink alcohol? ____Y/N How many? _____ Drinks/ Week

Do you drink coffee/tea/caffeine? _____ Y/N How many cups/cans per day?_____

Level of stress in your life: MILD MODERATE EXTREME Reason for stress _____

MEDICATIONS: _____

ALLERGIES: _____

VITAMINS/HERBS/SUPPLEMENTS: _____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient's/Guardian's signature _____ Date _____