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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 EMERGENCY, 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** \_\_\_\_\_