PATIENT REGISTRATION FORM

Name:________________________________ Date:____________________
Address:____________________________________
City/State/Zip Code:___________________________
Sex: M/F Marital: M/S/D/W DOB:_____________ Age:______
Home Phone #:______________ Work #:__________ Cell #:______________
Email:__________________________ Occupation:______________________
Emergency Contact:________________ Phone Number:___________________

Race: (Circle) American Indian Alaska Native Asian Black or African American Decline to State Native Hawaiian Other Pacific Islander White

Ethnicity: (Circle) Decline to state Hispanic or Latino Not Hispanic or Latino

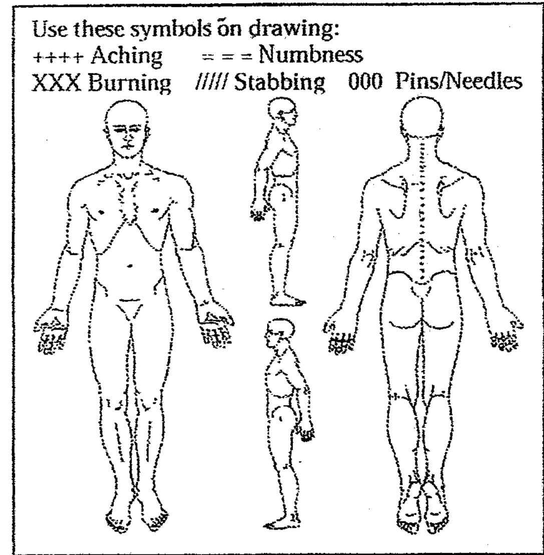
Language Spoken: ____________________________________

NATURE OF COMPLAINT:

List the major complaints you would like addressed:
Rate the average pain scale (PS) after each item, on a scale Of 0 to 10 with 0=no pain 10= unbearable pain.

1. Main ______________________ PS____
2. ______________________ PS____
3. ______________________ PS____
4. ______________________ PS____

PLEASE FILL OUT PAIN DRAWING AT RIGHT



HISTORY OF MAIN COMPLAINT:

Do any of these complaints seem related: Y/N
When did this episode begin? __________
Have you had similar symptoms before? Y/N
When? ______________
How did it occur? (Circle) Gradually Suddenly
No apparent reason Bending Lifting Fall
Motor Vehicle accident Work related
Has your pain: (circle) Improved Worsened Not changed
Is your pain: (circle) Constant Intermittent Daily Weekly
Does it interfere with (circle) Work Sleep Daily routine Exercise
What activity is limited most by pain? __________________

PRIOR TREATMENT OF MAIN COMPLAINT:

Have you seen anyone else for these symptoms: Y/N Who?______________________
What did they recommend?______________________________________
Test results for x-ray/Lab/CT/MRI or other:____________________________

Surgery: Year/ Type:______________________________ results: Better No Change Worse
Chiropractic: Year_________________________________ results: Better No Change Worse
Physical Therapy: Year_____________________________ results: Better Not Change Worse

FAMILY MEDICAL HISTORY: CIRCLE

Arthritis Diabetes Heart Disease High Blood Pressure Cancer Scoliosis Muscle Disease Rheumatoid Arthritis

Living Parents? Mother Y/N Died at age: ___ of ______________________________

Father Y/N Died at age:____ of ______________________________

YOUR MEDICAL HISTORY: CIRCLE

Anemia Arthritis Asthma Alcoholism Cancer Depression Diverticulitis Diabetes Glaucoma GERD Hepatitis High Blood Pressure Heart Disease Joint Replacement Kidney Disease Lung Disease Lupus Migraine Headaches Prostate Polio Stroke Seizures Scoliosis Sinus trouble Thryroid Disease Ulcers

Women only: Are you pregnant or is there a possibility you may be pregnant? Y/N/ Uncertain

Current Work Status: Circle Regular duty Limited/Light duty Off work date began_________

Lifestyle Habits: Circle Tobacco Y/N If so how much?______ Have you smoked in the past? Y/N

Alcohol Caffeine beverages

Height:_______________

Weight:_______________

LIST OF CURRENT MEDICATIONS: Please list amount taken for each.

____

____

____

____

ALLERGIES TO MEDICATIONS: Y/N IF SO PLEASE LIST.

____

____

SURGERIES/HOSPITALIZATIONS/FRACTURES/DISLOCATIONS:

____ **YEAR:**_______

____ **YEAR:**_______

____ **YEAR:**_______

____ **YEAR:**_______

Would you like to view your clinical summaries on line? Y/N

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account on receipt. However, I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient or Guardian's signature:____ Date:___________