Patient Registration and Health History

Name:______________________________________ Date of Birth:___________________________

Street Address:____

City:______________________________________ State:___________ Zip:_________________

Home Phone:____________________________ Cell Phone:_________________________________

Email Address:____

Gender: ___Female ___Male Social Security Number:__________________________________

Occupation:___________________________ Employer:___________________________________

Business Address:____

City:______________________________________ State:___________ Zip:_________________

Business Phone:___________________________ Fax:____________________________________

Spouse's Name:________________________________ Phone:______________________________

Number of Children:__________ Ages and Names of Children:_________________________

How did you find out about us?____

Emergency Contact

Contact Name:_________________________________ Relationship:_______________________

Phone:_________________________ Address:____

Current Health Profile

Primary Reason for Visit:____

Other doctors seen for this condition:____

Other treatment received for this condition:____

Date of last physical examination:____

Have you ever received chiropractic care before? ___No ___Yes, describe:_____________

Do you have a history of stroke or high blood pressure? ___No ___Yes, describe:______

Have you had any major illnesses (e.g. cancer, diabetes, heart disease, etc.)?_______

List any spinal surgeries with dates:____

List any other surgeries with dates:____

List any major injuries or falls with dates:____

Patient's Initials:________

List any auto accidents with dates:____

Have you been treated for any health condition(s) by a physician in the past year? ___No ___Yes

If yes, please describe:____

What medications are you taking?____

What nutritional supplements are you taking?____

Do you have allergies of any kind?____

Women: Are you pregnant? ___No ___Yes ___Unsure How many weeks?_____________________________

Previous birth(s) information?____

Social History

What type of regular exercise do you perform? ___Light ___Moderate ___Vigorous ___None

How many 8oz cups of water do you drink per day? ___1-2 ___3-4 ___5-6 ___7-8 ___9-10 ___Other:_____

Do you drink caffeinated beverages? ___No ___Yes, drinks per day?____ per week?____ per month?____

Are you on a special diet? ___No ___Yes, describe:____

Do you drink alcohol ___No ___Yes, drinks per day?____ per week?____ per month?____

Do you use any recreational drugs? ___No ___Yes

Do you use tobacco of any kind? ___never ___in the past ___current user (___often or ___sometimes)

How many hours of sleep are you getting per night? ___less than 5 ___6-8 ___8-10 ___10 or more

Rate your sleep: ___wake fully rested ___wake moderately rested ___wake poorly rested

Rate your stress level (please circle): No Stress 0 1 2 3 4 5 6 7 8 9 10 Very Stressed

List your major stressor(s):____

What are your health goals?____

Family History

Please indicate if an immediate family member has had any of the following:

Cancer – list family member(s) and describe:____

Heart Problems – list family member(s) and describe:____

Diabetes – list family member(s) and describe:____

Other – list family member(s) and describe:____

Review of Systems

Please circle any and all issues you have or are currently experiencing:

General	chills fever	headache fatigue	weight gain weight loss	night sweats drowsiness	loss of appetite
Eye/Vision	blindness glaucoma	eye pain itching	tearing cataracts	light sensitive double vision	change in vision glasses/contacts
Respiratory	asthma	congestion	shortness of breath	coughing	wheezing

Patient's Initials:________

Ears, Nose & Throat	bleeding discharge loss of smell snoring	congestion drainage TMJ issues sore throat	sinus infections ear infections dental implants hearing loss	postnasal drip hard to swallow ear pain loss of taste	hoarseness dizziness tinnitus (ringing)
Heart	chest pain sleep apnea Pacemaker	heart murmur leg pain swelling	palpitations difficulty breathing stroke	high blood pressure low blood pressure circulation issues	varicose veins heart attack
Digestion	diarrhea heartburn ulcers belching	indigestion nausea vomiting loss of appetite	rectal bleeding abdomen pain difficulty swallowing	constipation jaundice gallbladder issues	abnormal stools hemorrhoids liver issues
Female	cramps discharge	birth control kidney issues	frequent urination bladder issues	breast lump/pain irregular cycles	hormone therapy menopause
Male	burning urination frequent urination		difficulty w/urination prostate issues	erectile dysfunction bladder issues	kidney issues
Skin	nail changes hair loss	itching hives	numbness skin lesions	rash changes in skin color	shingles skin disorder
Neurologic	dizziness memory loss tremors	headache balance loss stroke	numbness sleep disturbance limb weakness	weakness unsteady gait facial weakness	seizures fainting
Psychologic	anxiety bipolar	confusion convulsions	depression insomnia	behavioral changes mood changes	appetite changes nervousness
Endocrine	diabetes goiter	heat sensitive cold sensitive	increased appetite frequent urination	excessive thirst excessive hunger	hair loss voice changes
Hematoglogic	anemia blood clotting	bleeding HIV	bruises easily blood transfusion	swollen lymph nodes	fatigue
Musculoskeletal		arthritis	osteoporosis	Rheumatoid arthritis	

Please list any other conditions you feel we should know about – even if unrelated:___________________________

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I certify that the information I provided on this form is accurate to the best of my knowledge.

Patient Name (print):____

Patient Signature:____ **Date:**______________

Guardian/Spouse Authorizing Care (print):____________________________________

Guardian/Spouse Signature:____ **Date:**______________