Registration and History Form

Date_____

Patient Last Name _____ First Name _____

Date of Birth _____ Sex: M __ F ___ Age: _____

Address_____City_____Zip_____

E-Mail_____ Phone Numbers: Cell_____ Home_____

Marital status (please circle): Married / Single / Divorced / Separated / Widowed

Occupation: _____Employer _____
Work Phone: _____

Spouse's name _____Spouse's employer _____

Emergency contact Name _____ Emergency Phone number _____

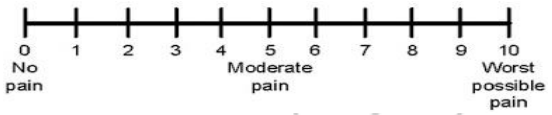
How did you hear about us? _____

Patient Condition:

Reasons for visit? _____

When did your symptoms first appear? _____

Is this condition getting progressively worse? _____Yes _____ No



Rate the severity of pain :

Type of pain (Please circle): Sharp / Dull / Burning / Tingling / Throbbing / Numbness / Stiffness / Aching / Swelling / Shooting / Cramps / other _____

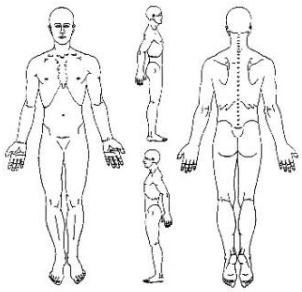
How often do you have this pain? _____ It is worse during ___AM ___PM hours

Is it constant or does it come and go? _____

What activities does it interfere with? ____ Work _____ Sleep _____ Activities of daily living _____ Recreation _____Exercise

Activities or movements are painful for me to perform: _____ Sitting _____ Standing _____ Walking _____Bending ___ Lying down _____ Getting in/out of the car _____ Getting up from bed/chair

Mark an X on the picture below where you have pain, numbness or tingling



What treatment have you already received for your condition? ____Chiropractic Adjustments ____ Medication ___ Surgery _____ Physical Therapy _____ None ___ Other _____

Have you ever had chiropractic care before? _____Yes (When was the last visit?) _____No (If yes, why have you discontinued care?
_____)

Are you pregnant? ____Yes ___No Due Date _____

Date of last:

Spinal exam _____ Spinal X-Ray _____ MRI, CT-Scan, Bone scan _____

Injury History:

Injuries / _____Date _____

Falls _____ Date _____

Auto Accidents_____ Date _____

Hospitalization _____ Date _____

Surgeries you have had_____ Date _____

Any other previous medical conditions _____

Medication _____

*Allergies*_____

Vitamins/Herbs/Minerals _____

Please mark in each column which boxes best describe your activities:

WORK ACTIVITY	HABITS	EXERCISE
__Sitting	__ Smoking Packs/Day _____	___ None
__Standing	__ Alcohol Drinks/Week _____	___ Moderate
__Light Labor	__Coffee/Caffeine Cups/Day _____	___ Daily
__ Heavy Labor	__ High Stress Levels Reason _____	___ Heavy