PATIENT REGISTRATION FORM

CHART NO. _____

Please fill out the following form in as much detail as possible.

Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ E-mail Address _____

Age _____ Date of Birth _____ Occupation _____ Language_____ Sex (M) (F)

Weight _____ Referred by _____

Employer _____ Address _____

Married ___ S ___ W ___ D ___ Children____ Name of Spouse _____

Is any other member of your family being treated in this office? _____

Have you ever had chiropractic care before? _____

For what problem? _____

Were the results satisfactory? Yes_____ No_____ N/A_____

Major complaints and symptoms — please be as specific as you can. Ask the doctor or nurse for help if you need assistance in filling out this section. _____

_____

How do you believe your problem (pain) began? _____

_____

Have you lost any work? _____ Day and date you last worked _____

Have you ever had this condition before or a similar condition? _____

When? _____

What positions or activities aggravate your condition? _____

What positions or activities relieve your condition? _____

Have you ever been treated by a Medical Physician for this ailment?_____

Where? _____

Diagnosis of previous physician _____

Length of time under care_____ Results _____

Family physician's name _____

Please send a report to my family physician. Yes____ No ____

Will this case be covered by any insurance company? Major Medical _____ Auto _____ Blue Cross/Blue Shield ____ Workers' Compensation ____ Medicare _____ Other _____

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc. (even as a child)?_____ When? _____

Are you allergic to anything you are aware of? _____

Are you presently taking any medication, herbs, or over the counter products (aspirin included)? Yes_____ No_____

If yes, name them _____

Have you ever broken any bones? (fractures) _____ Any dislocations? _____

What operations have you had? _____Year _____

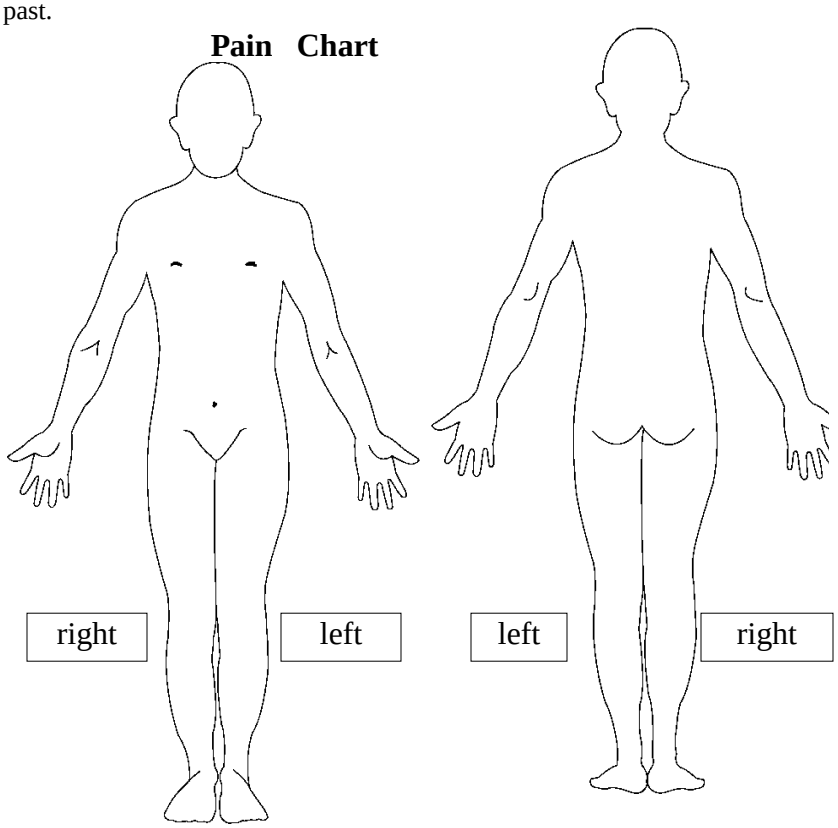
_____Year _____

_____Year _____

Have you had any surgery to replace hip, knee, etc.? _____Year _____
Give dates you have had any of the following? (if exact date is unknown, give approximate)
Blood tests _____ Urinalysis _____
MRI _____ CT Scan _____ Ultrasound _____
Radiation Treatment _____ X-Ray examination _____
Other special treatment _____
At what hospital or office were these tests taken _____
Name of doctor who ordered tests _____
Date of last menstrual period _____
Do you have any reason to believe that you may be pregnant? Yes _____ No_____
Do you have any health problems not listed above? _____
Do you faint easily? _____
Do you take vitamins? Yes_____ No _____ If yes, please list them _____
Do you exercise regularly? Yes ____ No ____ What kind of exercise? _____
Habits: (please check) Cigarettes ?_____ Quantity _____ Coffee? _____ Quantity _____
Alcohol? _____ Quantity _____ Tea? _____ Quantity _____
Hobbies _____
Have you been treated for any health condition by a physician in the past year? _____
If yes, what condition? _____
Have you lost or gained weight in the past year? _____
Use this space for any additional information you may wish to discuss _____
_____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter **N** if you have these conditions now (within the past 12 months) or **P** if you ever had these conditions in the past.

Pain Chart



NECK-SHOULDER-ARM PAIN
On a scale of zero to 10, rate discomfort as follows:
(_____)
0 10
no pain severe pain

MID BACK PAIN
On a scale of zero to 10, rate discomfort as follows:
(_____)
0 10
no pain severe pain

LOW BACK& LEG PAIN
On a scale of zero to 10, rate discomfort as follows:
(_____)
0 10
no pain severe pain

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charges 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 me will be immediately due and payable.

PATIENT SIGNATURE _____SSN _____ DATE _____