Chiro-Med REGISTRATION FORM

PATIENT INFORMATION:

TODAY'S DATE _____

PATIENT NAME _____ **PATIENT DATE OF BIRTH** _____

MARITAL STATUS MARRIED DIVORCED SINGLE WIDOWED

CELL PHONE _____ **HOME PHONE** _____ **WORK PHONE** _____

STREET ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

EMAIL ADDRESS _____

SOCIAL SECURITY NUMBER _____ **DRIVERS LICENSE #** _____

EMPLOYER COMPANY NAME _____ FULL TIME PART TIME AS NEEDED

OCCUPATION _____ **EMPLOYER PHONE** _____

EMPLOYER ADDRESS _____

EMPLOYER CITY _____ **STATE** _____ **ZIP CODE** _____

PREGNANT YES NO **PACEMAKER** YES NO **FAMILY PHYSICIAN** _____

EMERGENCY CONTACT NAME _____ **PHONE #** _____

INSURANCE INFORMATION:

PLEASE LIST ANY AND ALL INSURANCE YOU OR YOUR SPOUSE MAY HAVE:

1) INSURANCE COMPANY OR HEALTH PLAN NAME _____

POLICY # _____ **GROUP #** _____

EFFECTIVE DATE _____

INSURED PERSON'S NAME _____

RELATIONSHIP TO INSURED PERSON _____

2) INSURANCE COMPANY OR HEALTH PLAN NAME _____

POLICY # _____ **GROUP #** _____

EFFECTIVE DATE _____ **INSURED PERSON'S NAME** _____

RELATIONSHIP TO INSURED PERSON _____

OTHER INFORMATION:

Are your present symptoms or conditions related to or the result of an automobile accident, work injury, or other personal injury that someone else might be legally liable for? YES NO

INITIAL _____

If you answered yes above, please fill out an accident specific form, available at the front desk.

Chiro-Med REGISTRATION FORM

WHAT IS YOUR PRIMARY COMPLAINT? _____

HOW LONG HAVE YOU HAD THIS CONDITION? _____

HAVE YOU HAD THIS OR SIMILAR CONDITIONS IN THE PAST? _____

WHAT POSITIONS MAKE IT FEEL WORSE? _____

WHAT POSITIONS MAKE IT FEEL BETTER? _____

HAS THIS CONDITION IMPROVED WORSENED UNCHANGED

DOES THIS CONDITION INTERFERE WITH YOUR WORK SLEEP DAILY ROUTINE OTHER _____

OTHER DOCTORS/THERAPISTS WHO HAVE TREATED THIS CONDITION _____

WHAT DO YOU THINK CAUSED THIS CONDITION? _____

LIST SURGICAL OPERATIONS AND YEARS _____

_____

Would you be interested in our Dr. Monitored Weight Loss Program

_____Yes _____No

OFFICE USE ONLY

DOCTOR'S RECOMMENDATIONS: **ICE PACK: SMALL LARGE**

CERVICAL SPINE : CERVICAL COLLAR CERVICAL TRACTION UNIT CERVICAL PILLOW

LUMBAR SPINE: LUMBAR BRACE LUMBAR BELT

SHOULDER: SHOULDER BRACE SHOULDER HARNESS

WRIST: WRIST BRACE STIFFNESS: STRETCHING EXERCISES

KNEE: KNEE BRACE WEAKNESS: STRENGTHENING EXERCISES

ANKLE: ANKLE BRACE

Chiro-Med PATIENT HISTORY FORM

PLEASE CIRCLE ANY ISSUES YOU HAVE CURRENTLY OR HAVE HAD IN THE PAST:

BREASTS	DISCHARGE	PAIN	LUMPS	BLEEDING	NIPPLE/SKIN CHANGES	
BLOOD	ANEMIA	LOW IRON	RED SPOTS	PAINFUL NODES		
EARS	DEAFNESS	RINGING	DISCHARGE	EAR ACHE	ITCHING	SPINNING
ENDOCRINE	WEIGHT LOSS/GAIN		HEAT/COLD INTOLERANCE		HAIR/BREAST CHANGES	
GASTROINTESTINAL		PAIN	NAUSEA	BLOATED	CONSTIPATION	BLOODY STOOLS
GENERAL	WEAKNESS	FATIGUE	FEVER CHILLS	NIGHT SWEATS	FAINTING	
GENTITOURINARY		URGENCY	INCONTINENCE	STRAINING	DISCHARGE	BURNING
HEAD	HEADACHES	INJURIES	BUMPS			
HEART	CLOTS	PAIN	PRESSURE	PALPITATIONS	MURMUR	FAST HEARTBEAT
IMMUNIZATION	DPT	MMR	SMALLPOX	TETANUS	INFLUENZA	
LUNGS	COUGH	PHLEGM	BLOOD	WHEEZING	SHORT OF BREATH	
MOUTH	BLEEDING	PAIN	DENTAL ISSUES	BAD BREATH	LOSS OF TASTE	DRY MOUTH
MUSCULOSKELETAL		PAIN	WEAKNESS	CRAMPS	TWITCHING	STIFFNESS
NECK	SORENESS	STIFF	LUMPS	MASSES	ENLARGEMENT	
NEUROLOGIC	SEIZURES	VERTIGO	DIZZINESS	PARALYSIS	TINGLING	NUMBESS
NOSE	BLEEDING	PAIN	DISCHARGE	CONGESTION	DEVIATED SEPTUM	
PSYCHIATRIC	IRRITABLE	WORRY	ALCOHOLISM	HALLUCINATIONS		TROUBLE SLEEPING
SKIN CHANGES	NAILS	HAIR	MOLES/RASHES	SORES		
THROAT	SORENESS	PAIN	BAD TONSILS	INFECTIONS	TROUBLE SWALLOWING	

FAMILY HISTORY (LIST ANY DISEASE THAT RUN IN YOUR FAMILY)

RELATIVE_____ **ILLNESS**_____
RELATIVE_____ **ILLNESS**_____
RELATIVE_____ **ILLNESS**_____
RELATIVE_____ **ILLNESS**_____
RELATIVE_____ **ILLNESS**_____

SOCIAL HISTORY

CURRENT WEIGHT_____ **RECENT WEIGHT CHANGES** LOSS GAIN
SMOKING HISTORY SMOKER?: NO ___ YES/YEARS ___/_____ PACKS/PER DAY ___
PHYSICAL WORK LIGHT MODERATE HEAVY **FOR _____ HOURS DAILY**
EXERCISE LIGHT MODERATE HEAVY **FOR _____ HOURS PER WEEK**

Chiro-Med PATIENT HISTORY FORM

PLEASE FILL OUT THIS FORM AS ACCURATELY AS POSSIBLE. MARK THE AREA(S) ON THE BODY DIAGRAM WHERE YOU FEEL YOUR DESCRIBED SYMPTOM(S). USE THE APPROPRIATE SYMBOL(S) TO MARK THE AREAS OF THE BODY. INCLUDE ALL AFFECTED AREAS.

ACHES = 0
ACHES = 0
NUMBNESS = ▲
PINS/NEEDLES = □
BURNING SENSATION = x
STABBING SENSATION = /

INDICATE THE SEVERITY OF YOUR SYMPTOMS BY MARKING AN "X" ON THE LINES BELOW.

HOW BAD ARE YOUR SYMPTOMS NOW?
NONE _____ SEVERE

HOW BAD HAVE YOUR SYMPTOMS BEEN IN THE PAST?
NONE _____ SEVERE