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 #**_____

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

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	NUMBNESS STROKE
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

Cigarettes Yes/No Packs a day_____ Years of Use_____
Other tobacco use:_____
CURRENT WEIGHT_____ **RECENT WEIGHT CHANGES** LOSS GAIN
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