



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.

PATIENT NAME _____



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 WORSENERD 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:

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

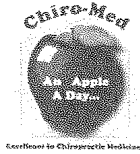
Cigarettes Yes/No Packs a day _____ Years of Use _____

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

