

REGISTRATION

Date _____ Home Phone _____

Patient _____
Last Name First Name Initial

Street Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Social Security # _____ Driver's License # _____

Insured's Name _____
Last Name First Name Initial

Relationship To Insured Self Spouse Child Other Condition Related to Illness Employment Auto Other

EMPLOYER	Company Name _____ Occupation _____ Address _____ Phone _____ City _____ State _____ Zip _____	
SPOUSE	Name _____ <small>Last Name First Name Initial</small> Birthdate _____ Social Security # _____ Employer Name _____ Occupation _____ Address _____ Phone _____ City _____ State _____ Zip _____	
PATIENT INSURANCE INFORMATION	Please <input checked="" type="checkbox"/> any and all insurance coverage you or your spouse has applicable in this case. <input type="checkbox"/> MEDICARE <input type="checkbox"/> BLUE SHIELD <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> MEDICAID <input type="checkbox"/> MAJOR MEDICAL <input type="checkbox"/> UNION PLAN <input type="checkbox"/> BLUE CROSS <input type="checkbox"/> WORKER'S COMPENSATION <input type="checkbox"/> OTHER BCBS I.D. # _____ MEDICARE/MEDICAID I.D. # _____ MAJOR MEDICAL OR AUTO INSURANCE Date of accident _____ Insurance Company Name _____ Adjuster _____ Address/Phone _____ Claim # _____ Policy # _____ Effective Date _____	
SPOUSE CO-INSURANCE INFORMATION	MAJOR MEDICAL ONLY Insurance Company Name _____ Address/Phone _____ Policy # _____ Effective Date _____	
MEDICAL AND LEGAL INFORMATION	Referred by _____ Present Complaint _____ Known Medical Problems _____ _____ Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No Family Physician _____ Person to contact in emergency (Name and Phone #) _____	Attorney _____ Address _____ _____ Phone _____
PATIENT AGREEMENT	ASSIGNMENT AND RELEASE I, the undersigned, have insurance coverage with _____ <small>Name of Insurance Company</small> and assign directly to Dr. _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. _____ <small>Signature of Insured/Guardian Date</small>	

THE STRESS TEST

PATIENT: _____ DATE: _____

The following three areas of stress can cause a misaligned vertebra (subluxation). Do you recognize any of these stresses? Please circle when you experienced these stresses: C (child), T (teenager), A (adult), or N (not at all).

I. PHYSICAL STRESS:

EXPLAIN

Birth Traumas (as a mother or child)	C	T	A	N	_____
Slips/Falls	C	T	A	N	_____
Car Accidents	C	T	A	N	_____
Sports Injuries	C	T	A	N	_____
Physical Abuse	C	T	A	N	_____
Work Injuries	C	T	A	N	_____
Poor Posture	C	T	A	N	_____
Sitting on your wallet for years	C	T	A	N	_____
Sleeping Position - Stomach	C	T	A	N	_____
Extensive Computer Work	C	T	A	N	_____
Carrying Heavy Purse/Bookbag/Child	C	T	A	N	_____
Repetitive Lifting/Bending	C	T	A	N	_____
Driving for Many Hours	C	T	A	N	_____
Continuous Hours Sitting/Standing	C	T	A	N	_____
Bone Fracture/Surgery	C	T	A	N	_____

II. EMOTIONAL STRESS:

EXPLAIN

Relationships	C	T	A	N	_____
Career	C	T	A	N	_____
Children	C	T	A	N	_____
Money	C	T	A	N	_____
Fast-Paced Life	C	T	A	N	_____
Hold in Feelings	C	T	A	N	_____
Quick Tempered	C	T	A	N	_____
Verbal Abuse	C	T	A	N	_____
Perfectionist	C	T	A	N	_____
Procrastinator	C	T	A	N	_____
Sickness or Loss of Loved One	C	T	A	N	_____

III. CHEMICAL STRESS:

EXPLAIN

Environment (i.e. pollution)	C	T	A	N	_____
Smoker - Amount?	C	T	A	N	_____
Second-hand Smoke	C	T	A	N	_____
Poor Diet	C	T	A	N	_____
Caffeine - Amount?	C	T	A	N	_____
Excessive Sugar	C	T	A	N	_____
Artificial Sweeteners	C	T	A	N	_____
Prescription Drugs	C	T	A	N	_____
Over-The-Counter Drugs (Example: Tylenol; Motrin)	C	T	A	N	_____

IV. What do you feel is your primary stress? _____

HISTORY FORM
page two

History of the Current Problem

When did the problem begin? _____
Does it come & go or is it constant? _____
Anything relieve it? _____
Anything aggravate it? _____
Have you had this problem before? If so, when, how long did it last, and what treatments did you receive? _____
If there is pain associated with the problem.....
Would you characterize the pain as deep, achey, dull, throbbing, or sharp? _____
Does the pain stay local or does it go up or down the body? _____
On a scale of 1-10, 10 being the most severe, rate the pain. _____
Is the pain getting better or worse? _____

Past History

List the dates of any surgeries. + Type of Surgery. _____
List the dates of any hospitalizations. + Reason for hospitalization. _____
List the dates and severity of any automobile accidents. Include fender benders. _____
List any sports you play or have played and any injuries which have occurred. _____
List the dates & injuries from any falls (trees, houses, stairs). _____
List the dates of any major illnesses. _____
Females, list any problems with PMS or menstrual cycle. _____
What was your birth like? _____

Family History

List your siblings and their ages & if they have any health problems. _____
What is the health of your parents? _____

Medical/Social History

How many times in your whole life have you taken antibiotics? _____
Have you taken them recently? _____
Have you taken acidophilus? _____
Females, are you taking oral contraceptives? If yes, for how long? _____
Females, have you ever been pregnant? _____

Do you smoke? If yes, how much & for how long. _____
If you are an ex-smoker, when did you quit & how long did you smoke? _____
Do you drink? If yes, what do you drink, how much, & how often? _____
If you are sober, when did you quit & for how long did you drink? _____
Do you do any recreational drugs? If yes, what do you use, how much, how often, & for how long? _____
If you used to use drugs, when did you quit & what did you use? _____

What are your hobbies? _____

What kind of regular exercise do you do? _____
How often? _____

Diet History

List your typical breakfast. _____

List your typical lunch. _____

List your typical dinner. _____

List any snacks you typically have. _____

How much caffeinated coffee do you drink? _____ Tea? _____
Decaf coffee? _____ Herbal Tea? _____ Water? _____
Diet Soda? (list kind) _____ Regular Soda? (list kind) _____

Please use the space below to elaborate on your problem or give any information which might have been missed in the above questionnaire.

CHIROPRACTIC HEALTH QUESTIONNAIRE

Date _____

Patient name _____ Birthdate _____

Reason for visit _____

Have you been treated before for this problem? No Yes

If yes, by Physician Doctor of Chiropractic Physical Therapist Osteopath Other _____

What did they do and/or recommend? _____

When did your symptoms appear? _____ Is this condition getting progressively worse? Yes No Unknown

Is it constant or does it come and go? _____ Does it interfere with your Work Sleep Daily routine Recreation

Activities or movements that are painful to perform Sitting Walking Bending Lying down

Other _____

Your Occupation _____ (Describe activities - sitting, lifting, etc.)

Have you ever had chiropractic care for other problems? No Yes When? _____

Do you take Muscle relaxers Pain killers Insulin Birth control pills Over-the-counter meds

Other prescription drugs _____ Please list all medication in the space at bottom of page.

Date of last: Physical exam _____ Spinal x-ray _____ Blood test _____

Spinal exam _____ Chest x-ray _____ Urine test _____

Dental x-ray _____ MRI, CT-scan, bone scan _____

Sleep _____ hrs/night Do you sleep on your Back Side Stomach Non-job exercise _____ hrs/wk

Age of mattress _____ or waterbed _____ Is your bed comfortable? No Yes

What kind of pillow do you use? Thick Medium Thin None Support

Do you wear Heel lifts Shoe lifts Arch supports Orthotics, describe _____

CONDITIONS Check (✓) conditions you have or have had in the past.			
<input type="checkbox"/> AIDS	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Measles	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Fractures	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Suicide attempt
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tumors, growths
<input type="checkbox"/> Breast lump	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hernia	<input type="checkbox"/> Polio	<input type="checkbox"/> Vaginal infections
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Cataracts	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Other _____
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Rheumatoid arthritis	

MEDICATIONS List medications you are currently taking	VITAMINS/HERBS/MINERALS
Allergies _____	
Pharmacy Name _____ Phone _____	

GENERAL SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

<p>GENERAL</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Chills <input type="checkbox"/> Dental problems <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <input type="checkbox"/> Tiredness <input type="checkbox"/> Weight gain <p>GENITO-URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p>EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - flashes <input type="checkbox"/> Vision - halos <p>SKIN</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p>MEN only</p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other <p>WOMEN only</p> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other <p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>
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NECK, BACK, EXTREMITIES Check (✓) symptoms you currently have or have had in the past year.

<p>NECK</p> <input type="checkbox"/> Pain in neck <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Neck weakness <input type="checkbox"/> Pinched nerve in neck <input type="checkbox"/> Neck feels out of place <input type="checkbox"/> Muscle spasms in neck <input type="checkbox"/> Grinding/popping sounds in neck <p>SHOULDERS</p> <table border="0"> <tr> <td></td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> <tr> <td><input type="checkbox"/> Pain in shoulder joint</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain across shoulders</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Can't raise arm</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td> <input type="checkbox"/> Above shoulder level</td> <td></td> <td></td> </tr> <tr> <td> <input type="checkbox"/> Over head</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Tension in shoulders</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Pinched nerve in shoulder</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> </table> <p>MID-BACK</p> <input type="checkbox"/> Mid-back pain <input type="checkbox"/> Mid-back stiffness <input type="checkbox"/> Pain between shoulder blades		Right	Left	<input type="checkbox"/> Pain in shoulder joint	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Pain across shoulders			<input type="checkbox"/> Can't raise arm	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Above shoulder level			<input type="checkbox"/> Over head			<input type="checkbox"/> Tension in shoulders			<input type="checkbox"/> Pinched nerve in shoulder	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Pain from front to back <input type="checkbox"/> Muscle spasms in mid-back <p>ARMS & HANDS</p> <table border="0"> <tr> <td></td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> <tr> <td><input type="checkbox"/> Pain in upper arm</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in elbow</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in forearm</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in hand</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td 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L	<input type="checkbox"/> Pain in forearm	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Pain in hand	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Pain in fingers	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Pins & needles in arm	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Pins & needles in fingers	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Numbness in arm	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Weakness of arm	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Weakness of hand	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Hands cold	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Low back feels out of place <input type="checkbox"/> Muscle spasms in low back <p>HIPS, LEGS & FEET</p> <table border="0"> <tr> <td></td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> <tr> <td><input type="checkbox"/> Pain in buttocks</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in hip joint</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain down leg</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input type="checkbox"/> Pain in knee</td> <td style="text-align: center;"><input type="checkbox"/> R</td> <td style="text-align: center;"><input type="checkbox"/> L</td> </tr> <tr> <td><input 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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

<p>_____</p> <p>Patient Signature</p>	<p>_____</p> <p>Date</p>
<p>Reviewed by _____</p> <p>Doctor</p>	<p>_____</p> <p>Date</p>