File Number:_____

Chiropractic Registration Form

Date: _____

PLEASE TELL US ABOUT YOURSELF:

Name _____ Date of Birth (M/D/Y) _____
Address_____City_____
Postal Code _____Home/Cell Tel: _____ Work: _____
Emergency Contact Name and Phone Number:_____
Occupation _____Company Name: _____
E-mail_____ Email appointment reminder: Yes/ No
How did you hear about our clinic?_____

Health History:

Name of Medical Doctor: _____Date of last Physical exam:_____
Are you currently under Chiropractic care? Yes / No
If yes; when: _____ Reason:_____ Name of Chiropractor:_____
Have you had any previous Chiropractic care? Yes / No
If yes; when: _____ Reason:_____ Name of Chiropractor:_____

Please describe your PRESENT complaint:_____
_____
When did it occur? _____ How did it occur?_____
Have you received any treatment for this condition, and if so what kind of treatment?
_____
Has any treatment helped? _____
Have you ever had a similar problem to your current complaint? _____
Were X-rays taken? Yes/ No
Was this an injury that occurred at work? Yes / No. Was it reported? Yes / No
Was this an injury as a result of a car accident? Yes / No. Is there a claim pending? Yes / No

Do you currently smoke? Yes / No
Any Prior Surgery? _____
Prior Hospitalizations? _____
Have you broken any bones? _____
Do you currently take any prescription or over the counter medications or vitamins/nutritional supplements? Yes / No
Specify: _____

Female only:
Date of last menstrual period? _____ Are you currently pregnant? Y / N
Have you ever taken birth control pills? Y / N. Are you currently taking birth control pills? Y / N
How many children do you have? _____How many pregnancies?_____

File Number:_____

Client health history

Mark ☑ for current problems, and "X" to indicate previous problems.

General
□ Allergies
□ Depression
□ Dizziness
□ Fainting
□ Fatigue
□ Fever
□ Headaches
□ Loss of sleep
□ Mental illness
□ Nervousness
□ Tremors
□ Weight loss / gain

Muscle / Joint
□ Arthritis / rheumatism
□ Bursitis
□ Foot trouble
□ Muscle weakness
□ Low back pain
□ Neck pain
□ Mid back pain
□ Joint pain

Skin
□ Boils
□ Bruise easily
□ Dryness
□ Hives or allergies
□ Itching
□ Rash
□ Varicose veins

Eye, Ear, Nose & Throat
□ Colds
□ Deafness
□ Ear ache
□ Eye pain
□ Gum trouble
□ Hoarseness
□ Nasal obstruction
□ Nose bleeds
□ Ringing of the ears
□ Sinus infection
□ Sore throat
□ Tonsilitis
□ Vision problems

Gastrointestinal
□ Abdominal pain
□ Bloody or tarry stool
□ Colitis / Crohn's
□ Colon trouble
□ Constipation
□ Diarrhea
□ Difficult digestion
□ Diverticulosis
□ Bloated abdomen
□ Excessive hunger
□ Gallbladder trouble
□ Hernia
□ Hemorrhoids
□ Intestinal worms
□ Jaundice
□ Liver trouble
□ Nausea
□ Painful defication
□ Pain over stomach
□ Poor appetite
□ Vomiting
□ Vomiting of blood

Genitourinary
□ Bed-wetting
□ Bladder infection
□ Blood in urine
□ Kidney infection
□ Kidney stones
□ Prostate trouble
□ Pus in urine
□ Stress incontinence

Urination
□ Overnight more than twice
□ More than 8x in 24hrs
□ Decreased flow/force
□ Painful urination
□ Urgency to urinate

Cardiovascular
□ High blood pressure
□ Low blood pressure
□ Hardening of the arteries
□ Irregular pulse
□ Pain over heart
□ Palpitation
□ Poor circulation
□ Rapid heart beat
□ Slow heart beat
□ Swelling of ankles

Respiratory
□ Chest pain
□ Chronic cough
□ Difficulty breathing
□ Hay fever
□ Shortness of breath
□ Spitting up phlegm / blood
□ Wheezing

Check any of the conditions you have or have had:
□ Alcoholism
□ Anemia
□ Appendicitis
□ Arteriosclerosis
□ Asthma
□ Bronchitis
□ Cancer
□ Chicken pox
□ Cold sores
□ Diabetes
□ Eczema
□ Edema
□ Emphysema
□ Epilepsy
□ Goiter
□ Gout
□ Heart burn
□ Heart disease
□ Hepatitis
□ Herpes
□ High cholesterol
□ HIV/AIDS
□ Influenza
□ Malaria
□ Measles
□ Miscarriage
□ Multiple sclerosis
□ Mumps
□ Numbness/tingling
□ Pace maker
□ Osteoporosis
□ Pneumonia
□ Polio
□ Rheumatic fever
□ Stroke
□ Thyroid disease
□ Tuberculosis
□ Ulcers

What would you like to achieve by coming to our clinic? _____
(Our primary goal is always to work toward the resolution of your condition as quickly as possible!)
Do you have any concerns about the therapy that you would like us to address before we begin treatment?
_____
(We believe that good client communication is essential and we always want to know your perspectives – positive or negative.)

File Number:_____

Symptom Diagram

Indicate the severity of your symptoms on the line below with an "X":

0 — 10

No symptoms — Extreme Symptoms

Please circle the area of complaint and indicate the type of symptoms on the diagram below with the following symbols:

ACHE	x x x x x x	STABBING	2 2 2 2 2 2	PINS & NEEDLES	* * * * * *
STIFFNESS	0 0 0 0 0 0	NUMBNESS	+ + + + + +	Burning	Δ Δ Δ Δ Δ Δ