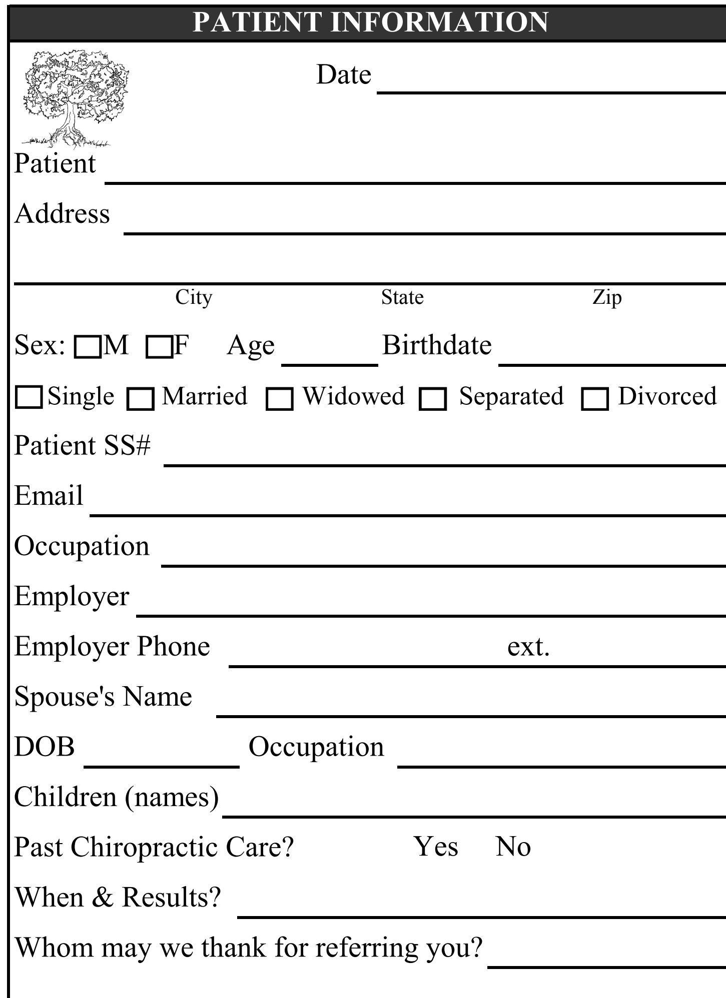
CHIROPRACTIC REGISTRATION AND HISTORY



PATIENT INFORMATION

Date ____________________

Patient ____________________

Address ____________________

____
City State Zip

Sex: ☐M ☐F Age ______ Birthdate ____________

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient SS# ____________________

Email ____________________

Occupation ____________________

Employer ____________________

Employer Phone ____________ ext. ______

Spouse's Name ____________________

DOB ________ Occupation ____________

Children (names) ____________________

Past Chiropractic Care? Yes No

When & Results? ____________________

Whom may we thank for referring you? ____________

PHONE NUMBERS

Cell ____________ Home ____________

Best time and place to reach you ____________

IN CASE OF EMERGENCY, CONTACT

____

Name ____________ Relationship ____________

Home Phone ________ Cell Phone ________

MAJOR INJURIES & ACCIDENTS

(broken bones, falls, sports injuries, auto accidents, etc.)

Description	Date

ACCIDENT INFORMATION

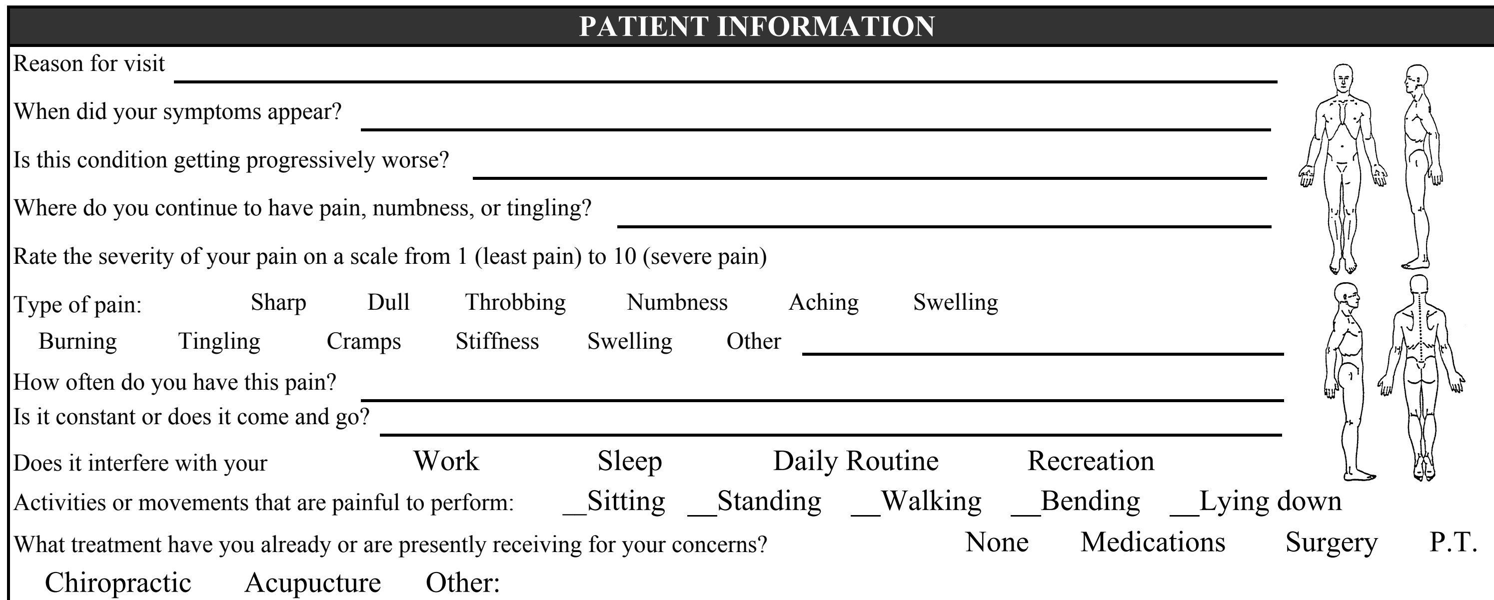
Is condition due to an accident? Yes No Date ______

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable)



PATIENT INFORMATION

Reason for visit ____________________

When did your symptoms appear? ____________________

Is this condition getting progressively worse? ____________________

Where do you continue to have pain, numbness, or tingling? ____________________

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

Type of pain: Sharp Dull Throbbing Numbness Aching Swelling
Burning Tingling Cramps Stiffness Swelling Other ____________

How often do you have this pain? ____________________

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 __Standing __Walking __Bending __Lying down

What treatment have you already or are presently receiving for your concerns? None Medications Surgery P.T.
Chiropractic Acupucture Other:

Patient/Guardian's Signature ____________________

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