CHIROPRACTIC REGISTRATION AND HISTORY

(Please Print)

Patient Name:___________________________________ Date:________________

Address:___________________________________ City:______________________

State:__________ Zip:___________ Age:_____ Birth date:______________________

Phone:____________________ email:____

Sex: ❑ M ❑ F Occupation:____

Spouse's (or significant other) Name:____

Phone:____________________ Referred by:____________________________________

Primary complaint:____

When did your symptoms first occur:____

Has your complaint been getting worse? ❑ Yes ❑ No

What other care have you had for this complaint:_______________________________

____

Is this complaint due to an accident: ❑ Yes ❑ No Date:________________________

Type of accident: ❑ Auto ❑ Work ❑ Home ❑ Other :__________________________

Secondary complaint:____

Please list the medications which you are presently taking (and what for).

____

____

____

____

Please list the vitamins/herbs/minerals you are presently taking.

____

____

____

Allergies:____

____

Page two Health History

Place a mark on "Yes" or "No" to indicate if you have any of the following:

Condition		Condition		Condition	
Acid Reflux	☐ Yes ☐ No	Diverticulitis	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Pace Maker	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Parkinson's disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gonarrhea	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Prostate problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Psychiatric care	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herniated disc	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
		Headaches	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	M.S.	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Gall Bladder removal	☐ Yes ☐ No

Other:____

HABITS:

Smoking	☐ Yes ☐ No	Packs/day_______________	
Alcohol	☐ Yes ☐ No	Drinks/week_____________	
Coffee	☐ Yes ☐ No	Cups/day_______________	
Soda	☐ Yes ☐ No	Drinks (16 oz)/day________	

EXERCISE

☐ None
☐ Light (1-2 hours/week)
☐ Moderate (3-5 hours/week)
☐ High (daily 45-60 minutes)

Do you eat breakfast on regular basis (at least 5 days/week)? ☐ Yes ☐ No
Do you presently take a multiple vitamin? ☐ Yes ☐ No
Do you eat 3 meals/day? ☐ Yes ☐ No
Do you suffer from gas with meals? ☐ Yes ☐ No
Do you drink 8 glasses of water per day? ☐ Yes ☐ No
Would you like to improve your present level of fitness? ☐ Yes ☐ No
Would you like to schedule a consult to discuss our personal training programs ☐ Yes ☐ No
Do your activities at work irritate your present complaint? ☐ Yes ☐ No
If yes, please explain what activity:________________________________
Do you sleep well at night (no interruptions 6-8 hours) ☐ Yes ☐ No
Do you have a massage on regular basis (at least 3x/year) ☐ Yes ☐ No

What are your expectations to care in our office? Quick Relief ☐ Yes ☐ No
Long lasting Relief ☐ Yes ☐ No Wellness care ☐ Yes ☐ No

Thank you for taking the time to complete this information. If there is a matter that we did not ask, please bring it up to the doctor during your examination. Our goal is to provide natural, drug free relief as rapidly as possible. In the process of achieving that we hope to help transform your health and fitness level, through massage, nutrition, chiropractic and exercise. Welcome to our Wellness Center.

Please bring this completed form to your appointment. Make sure that the date on the form corresponds with the date of your visit.