



Lebanon Chiropractic and Fitness
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:

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

HABITS:

Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Packs/day	_____
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drinks/week	_____
Coffee	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cups/day	_____
Soda	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you presently take a multiple vitamin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you eat 3 meals/day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suffer from gas with meals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink 8 glasses of water per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like to improve your present level of fitness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like to schedule a consult to discuss our personal training programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do your activities at work irritate your present complaint?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain what activity: _____	
Do you sleep well at night (no interruptions 6-8 hours)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a massage on regular basis (at least 3x/year)	<input type="checkbox"/> Yes <input type="checkbox"/> No

What are your expectations to care in our office?	Quick Relief	<input type="checkbox"/> Yes <input type="checkbox"/> No
Long lasting Relief <input type="checkbox"/> Yes <input type="checkbox"/> No	Wellness care	<input type="checkbox"/> Yes <input type="checkbox"/> 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.