Chiropractic Registration and History

Patient Information

Date_____ AHC#_____ DOB(MM/DD/YY)_____

Patient Name (first, last) _____Sex __M __F Age_____

Address_____

City_____ Postal Code_____E-mail_____

Occupation_____ Employer/School _____

Employer/School Phone _____Number of Children ___ Name, Age_____

Spouse's Name_____ Spouse's DOB(MM/DD/YY)_____

Whom may we thank for referring you? _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Phone Numbers

Home Phone(___)_____Cell(___)_____

Best time and place to reach you?_____

IN CASE OF EMERGENCY, CONTACT

Name_____Relationship_____Home Phone(___)_____Cell(___)_____

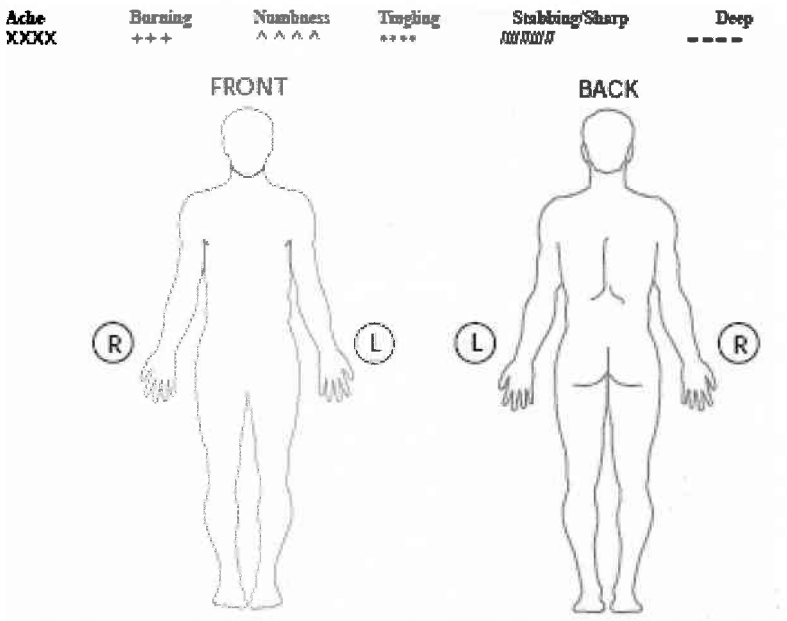
On the body, please mark where you have pain.

Please use the symbols above the chart:

Please rate the severity of pain:

0 1 2 3 4 5 6 7 8 9 10

No pain Extreme Pain



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 __Workers Comp __Other

Benefits

Do you have Secondary benefits? __Yes __No

They cover? __ Drugs __ Chiro __ Massage __ Orthotics __ Naturopath

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? __ Yes __ No __ Unknown

Type of pain :

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ 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

Activties or movements that are painful to perform __ Sittting __ Standing __ Walking __ Bending __ Lying Down

—O V E R—

Health History

What treatment have you already received for your condition? __ Medications __ Surgery __ Physical Therapy
__ Chiropractic Services __ None __ Other _____

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 _____

Place a mark under O– for Occasional, F—for Frequent, or C—for Constant if you have had any of the following:

Muscle & Joint	O	F	C
Back ache….	__	__	__
Neck pain……	__	__	__
Painful tailbone….	__	__	__
Foot Trouble……	__	__	__
Shoulder pain……	__	__	__
Hernia……	__	__	__
Spinal curvature…	__	__	__
Faulty posture……	__	__	__
Arthritis……..	__	__	__

General	O	F	C
Fever/Chills/Sweat…	__	__	__
Fainting……	__	__	__
Convulsions……	__	__	__
Allergy……	__	__	__
Skin Problems…….	__	__	__
Colds……	__	__	__
Tremors……	__	__	__
Loss of Balance……	__	__	__

Gastrointestinal	O	F	C
Difficult digestion….	__	__	__
Belching or gas…….	__	__	__
Nausea or vomiting..	__	__	__
Pain over stomach….	__	__	__
Constipation……..	__	__	__
Colon Trouble……	__	__	__
Liver Trouble……	__	__	__
Gall Bladder trouble..	__	__	__
Heartburn……	__	__	__
Diarrhea……	__	__	__
Bloody stools……	__	__	__

Cardiovascular	O	F	C
Rapid heart beat……	__	__	__
Slow heart beat…….	__	__	__
High blood pressure.	__	__	__
Low blood pressure..	__	__	__
Pain over heart…….	__	__	__
Swelling of ankles…	__	__	__

Previous heart attack Yes__No__
Poor circulation… Yes__No__
Previous Stroke….. Yes__No__

Stress Symptoms
Headaches/Migraine__ __ __
Dizziness…….. __ __ __
Numbness or pins & needles in arms ,legs…… __ __ __
Ringing in ears..__ __ __
Blurring of vision…__ __ __
Loss of sleep… __ __ __
Loss of concentration/ memory…… __ __ __
Irritability…….. __ __ __
Depression….. __ __ __
Tension…… __ __ __
Low energy…. __ __ __

Respiratory
Chronic cough…….. __ __ __
Spitting up phlegm… __ __ __
Chest pain…… __ __ __
Difficult Breathing… __ __ __

Urinary
Painful urination…… __ __ __
Getting up at night to urinate …… __ __ __
Blood in urine…… __ __ __
Increased urination Yes__ No__

Eyes, Ears, Nose, Throat
Deafness…… .. __ __ __
Earache…….. __ __ __
Sore throat…… __ __ __
Asthma…….. __ __ __
Tonsillitis…… __ __ __
Sinus trouble…….. __ __ __

Females Only
Painful menstruation Yes__No__
Excessive flow…….. __ __ __
Irregular cycle…….. __ __ __
Cramps or backache.. __ __ __
Abnormal discharge.. __ __ __
Passed menopause Yes__ No__
Birth control pill… Yes__ No__
Date of last menstrual period _____
Are you pregnant? Yes__ No__
Due Date:_____
No. of miscarriages_____

Exercise

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activity

☐ Sitting
☐ Standing
☐ Light Labour
☐ Heavy Labour

Habits

☐ Smoking
☐ Alcohol
☐ Coffee/Caffeine Drinks
☐ High Stress Level

Packs/Day_____
Drinks/week_____
Cups/Day_____
Reason_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications

Allergies

Vitamins/Herbs/Minerals

Pharmacy Name_____

Pharmacy Phone (___)_____