

Chiropractic Life Center, PC Registration & History Questionnaire

1. PATIENT INFORMATION

Last Name _____ MI _____ First Name _____

What do you prefer to be called? _____

Home Address _____ City _____ State/Zip _____

Age _____ Birth Date _____ (Circle one) Gender: **M** **F** Marital Status: **S** **M** **W** **D** **O**

Patient Social Security # (required for billing) _____

Would you like to receive our e-mail reminders? Yes No E-mail Address: _____

2. PATIENT PHONE NUMBERS

Patient Home Phone: _____ **In event of emergency :**

Patient Work Phone: _____ Name: _____ Relationship: _____

Patient Other Phone: _____ Home Phone _____ Work Phone: _____

Who is your Medical Dr.? _____ Phone: _____

3. PATIENT EMPLOYER / SCHOOL INFORMATION

(Please check one) Employed Retired Student Other _____

Employer Name _____ City: _____ State/Zip: _____

Address: _____

Phone: _____ Occupation: _____

Are you disabled? Yes No Date Disability Started: _____ (Required by HIPPA)

4. REFERRAL INFORMATION

How did you hear about our office? (please check one of the following)

Yellow Pages Newspaper Sign Dr. _____ Patient _____

Family _____ Website _____ Other _____

5 PATIENT CONDITION

Reason for Visit _____

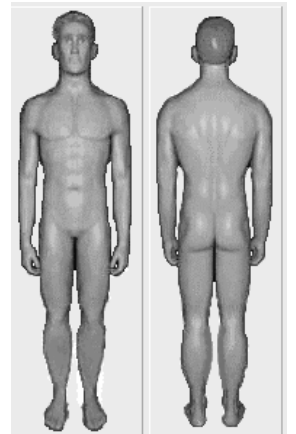
When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, tingling, or other symptoms

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

Type of Pain: Sharp Dull Throbbing Numbness
 Burning Tingling Cramps Stiffness
 Aching Swelling Shooting 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

Please continue to next page

6. HEALTH HISTORY

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

Name and address of Doctor(s) who have treated your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
 Spinal Exam _____ Chest X-Ray _____ Urine Test _____
 Bone Mineral Density Test _____ MRI, CT-Scan _____

Family Health History: (Circle) Spine problems Autoimmune disorders Arthritis Cancer Diabetes Heart disease
 Kidney disease Mental illness Seizures Other: _____

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

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<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	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<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	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<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	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
		Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

7. ACCIDENT

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) _____

WORK ACTIVITY

Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

Smoking Packs/Day ____
 Alcohol Drinks/Week ____
 Coffee/Caffeine Drinks Cups/Day ____
 High Stress Level Reason _____

Are you pregnant? Yes No Due Date _____

8. Injuries/Surgeries you have had

Description	Date
Falls	_____
Head Injuries	_____
Broken Bones	_____
Dislocations	_____
Surgeries	_____

9. MEDICATIONS

ALLERGIES

VITAMINS / HERBS / SUPPLEMENTS

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature _____

Date _____

Adult Patient Parent or Guardian Spouse

