New Patient Registration

If you need and assistance completing the paperwork, just ask. It is our pleasure to help you.

Confidential Health Information

Patient Personal Information

Last Name	First Name		m.i.
Street Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	SS#
Age	Date of Birth	Email	
Sex ☐ Male ☐ Female	Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Minor ☐ Widowed		
Primary Medical Doctor	Phone Number	Who referred you?	

Employment

Employer	Occupation	Phone Number	
Address	City	State	Zip

Spouse/Guardian

Last Name	First Name		m.i.
Date of Birth	SS#	Cell Phone	
Employer	Work Phone	Occupation	

Emergency Contact

Last Name	First Name		
Street Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Relationship to Patient			

Condition

Reason for visit

When did your symptoms start?

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

Mark an X on the picture where you have pain, numbness or tingling

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

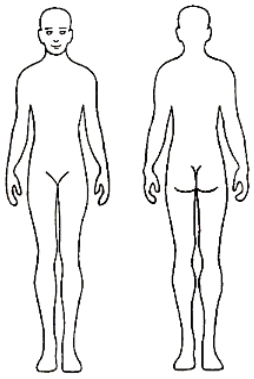
Type of pain ☐ Sharp ☐ Dull ☐ Cramps ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Throbbing ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain?

Is the pain constant or does it come and go?

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

What activities are painful to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Lying down



Health History

Patient Name

Last Name	First Name	m.i.

Treatment

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other

Conditions

Mark yes or no if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Polio	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Sciatica	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	STD	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Joint Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Carpal Tunnel	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Chemical Depend.	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Neck Pain	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Other_____	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	_____		
Fractures	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No			

Hospital/Medicine

Have you had breast implant surgery?	☐ Yes	☐ No
Have you had knee or hip replacement?	☐ Yes	☐ No
Do you have any implantable medical devices in your body?	☐ Yes	☐ No
Have you had any other surgeries or major medical conditions?	☐ Yes	☐ No

Diagnostics

Have you had any of the following diagnostic testing in the past year?

☐ MRI ☐ X rays ☐ CT ☐ Nerve Conduction Studies