Patient Registration and History

Patient Information Date: _____

Patient name: _____

Address:_____

_____

City State Zip

Home Phone: _____ Business Phone: _____ Cell: _____

Sex: ☐ Male ☐ Female Age: _____D.O.B. _____

Patient SSN (REQUIRED): _____

Occupation: _____

Employer: _____

Employer Address: _____

_____

Spouses Name: _____

Whom may we thank for referring you? _____

If nobody referred you how did you hear about us? _____

Is your condition due to an Accident? ☐ Yes ☐ No Date: _____

Work related? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No

Type of Accident? _____

E-mail address:_____

Would you like to receive a monthly newsletter? ☐ Yes ☐ No

Attorney Name (if applicable) _____

Primary Care Doctor

Name: _____

Address: _____

_____

Phone Number: _____

Last Time You Had Bloodwork:_____

Patient Condition
Reason for visit?
_____

When did this start? _____ Is Condition ☐ Better ☐Worse ☐Unchanged
How did it start? _____ Does it interfere with ☐Work ☐Sleep ☐Daily routine ☐Recreation
How frequent is your problem? ☐ Constant (76-100%) ☐Frequent (51-75%) ☐Occasional (26-50%) ☐Intermittent (25% or less)
How bad is your pain? (circle one…0 is no pain and 10 is the worst possible pain imaginable) 0 1 2 3 4 5 6 7 8 9 10
Type of Pain? ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramp ☐Stiffness ☐Swelling
Have you been treated for this condition before? ☐Yes ☐No If yes, by ☐Chiropractor ☐MD ☐DO ☐Physical Therapist ☐Other
What did they recommend? _____

Previous History	**Month/Year**	**Description**
Accidents/Injuries		
Surgeries		
Medications		

On a scale of 1 (Poor) to 10 (Optimum), mark your current health level in these seven essential areas:

Physical Health: What is your physical condition? Are you drinking plenty of water, receiving good nutrition, getting regular exercise and enjoying the proper weight for your height?
1 2 3 4 5 6 7 8 9 10

Mental Health: Are you open to new ideas? Do you seek out new experiences and learn new skills? What is the quality of the information and entertainment you follow in your mind?
1 2 3 4 5 6 7 8 9 10

Spiritual Health: How connected do you feel to the higher power in your life? Do you enjoy a sense of purpose and peace? Do you regularly study, meditate, pray or worship?
1 2 3 4 5 6 7 8 9 10

Family Health: Are you in a loving relationship with shared values? Do you give your family time and attention? Do you have a close connection with children parents and relatives?
1 2 3 4 5 6 7 8 9 10

Social Health: How well do you interact with people? Are you able to maintain long-term friendships? Are you comfortable in new situations and in the company of others?
1 2 3 4 5 6 7 8 9 10

Career Health: Do you like what you do for a living? Does your career reflect and advance your deepest values? Is your work meaningful and suited to your skills and interests?
1 2 3 4 5 6 7 8 9 10

Financial Health: Are you living within your means? Is your debt within manageable limits? Do you make charitable contributions and save for the future? Are you properly insured?
1 2 3 4 5 6 7 8 9 10

Your health affects everything you do and everyone you know. We use this confidential worksheet to record a "snapshot" of your estimated overall health so we can track your progress.

Are you interested in:	-Decreasing Body Fat and increasing lean muscle	☐YES ☐NO
	-Increasing overall strength 27%-85% in the next 12 weeks	☐YES ☐NO
	-Wellness and Maintenance care	☐YES ☐NO
	-A holistic approach to all of your health related problems	☐YES ☐NO
	-When you are pleased with your level of care will you help us to share the level of care we deliver to your friends	

and family ☐YES ☐NO

NECK
☐Pain in neck
☐Neck stiffness
☐Neck weakness
☐Pinched nerve in neck
☐Neck feels out of place
☐Muscle spasms in neck
☐Grinding/popping sounds

SHOULDERS Right Left
☐Pain in Shoulder ☐R ☐L
☐Pain across shoulders
☐Can't raise arm ☐R ☐L
☐Above shoulder level
☐Overhead
☐Tension in shoulders
☐Pinched nerve ☐R ☐L

MID BACK
☐Mid-back pain
☐Mid-back stiffness
☐Pain between shoulder blades
☐Pain from front to back
☐Muscle spasms in mid-back

ARMS & HANDS Right Left
☐Pain in upper arm ☐R ☐L
☐Pain in elbow ☐R ☐L
☐Pain in forearm ☐R ☐L
☐Pain in hand ☐R ☐L
☐Pain in fingers ☐R ☐L
☐Pins and needles in arm ☐R ☐L
☐Pins and needles in fingers ☐R ☐L
☐Numbness in arm ☐R ☐L
☐Numbness in fingers ☐R ☐L
☐Weakness of arm ☐R ☐L
☐Weakness of hand ☐R ☐L
☐Hands cold ☐R ☐L

LOW BACK
☐Low back pain
☐Low back stiffness
☐Low back weakness
☐Pinched nerve in low back
☐Low back feels out of place
☐Muscle spasms in low back

HIPS LEGS & FEET Right Left
☐Pain in buttocks ☐R ☐L
☐Pain in hip joints ☐R ☐L
☐Pain down leg ☐R ☐L
☐Pain in knee ☐R ☐L
☐Pain in ankle ☐R ☐L
☐Pain in foot ☐R ☐L
☐Weakness of leg ☐R ☐L
☐Weakness of knee ☐R ☐L
☐Leg cramps ☐R ☐L

OTHER SYMPTOMS
_____
_____
_____
_____
_____
_____

PLEASE GIVE SOME REAL THOUGHT TO THESE QUESTIONS:
What are your top 5 physical goals / dreams / aspirations?
1.
2.
3.
4.
5.

Do you currently have a plan to achieve them in the next 1, 3, 5 or 10 years. ☐YES ☐NO

What are your top 5 financial goals / dreams / aspirations?
1.
2.
3.
4.
5.

Do you currently have a plan to achieve them in the next 1,3,5,or 10 years? ☐YES ☐NO

☐I authorize use of these intake forms on all of my insurance submissions.
☐I authorize release of information to all my insurance companies.
☐I understand that **I am responsible** for my bill.
☐I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.
☐I understand that there may be charges that my insurance company may not cover.
☐I understand that I will be given a detailed-bill that I will be responsible to submit to my insurance company and that payment is expected upon services rendered.
☐I certify that this is not a workers compensation case and understand my doctor chose not to be on the workers comp board.
☐I permit a copy of this authorization to be used in place of the original.
☐I permit the release of my health information to the following family members _____
☐I understand that without filling in the names of family members above that under no circumstances will any information be given out without prior written consent. This is for your own privacy protection. Understand that even if someone from your family calls and is looking for you, we can't legally tell them you are at the office or are a patient if those names are not submitted above.
☐I certify that the information on all of my intake forms is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Patient Signature Date

Reviewed by_____ _____
Date