CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date_____

Patient Name_____

Last Name

_____

First Name *Middle Initial*

Email Address_____

Address_____

City_____

State_____ Zip Code_____

Birthdate_____ Age_____

Gender Male / Female

☐ Married ☐ Widowed ☐ Single

☐ Separated ☐ Divorced ☐ Minor

Occupation_____

Employer / School_____

Employer / School Address_____

_____

Employer / School Phone (____)_____

2 INSURANCE INFORMATION

Primary Insurance:

Insurance Company_____

Policy #_____Group #_____

If Subscriber is different than patient:

Name:_____

Birthdate:_____

Relationship to patient:_____

Secondary Insurance: None

Insurance Company_____

Policy #_____Group #_____

If Subscriber is different than patient:

Name:_____

Birthdate:_____

Relationship to patient:_____

Whom may we thank for referring you?

_____

3 PHONE NUMBERS

Best time and place to reach you:_____

Home Phone (_____)_____ Cell Phone: (_____)_____

In Case of Emergency, Contact:

Name:_____ Relationship:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

4 GENERAL HEALTH INFORMATION

Current Height:_____ Weight:_____

Medications _____

_____

_____

_____

Allergies _____

_____

Vitamins/Herbs/Minerals _____

_____

_____

5 PERSONAL HEALTH HISTORY (*not family history*) *(Check all that apply and describe)*

Arthritis _____
Asthma _____
Cancer _____
Diabetes _____
Digestive Problems_____
Eye, Ear, Nose, and Throat Conditions_____
Heart Disease _____
Herniated Disk _____
High Blood Pressure _____
High Cholesterol _____
Headaches _____
Hormone Imbalance_____
Infectious Disease (currently)_____
Liver Disease _____
Lung Disease_____
Migraine Headaches _____
Musculo/Skeletal Conditions_____
Neurological Conditions_____
Osteoporosis _____
Pacemaker _____
Pinched Nerve _____
Rheumatoid Arthritis _____
Stroke _____
Thyroid Problems _____
Tumors, Growths _____
Unexplained Weight Gain or Loss (past 6 months) ☐ Yes ☐ No _____
Night Pain ☐ Yes ☐ No _____
Treated for Anxiety/Depression ☐ Yes ☐ No _____
Other _____

6 INJURIES / SURGERIES *(date, description)*

Falls / Traumas / Injuries_____
_____
Surgeries _____
_____

7 EXERCISE

Describe Type_____
_____
Frequency_____

8 HABITS

Tobacco Use: ☐ Never Current Use: Years_____ Quit: (Date) _____
Type:_____
Vaping/E-Cigarettes: ☐ Never Start: (Date) _____ Frequency:_____ Quit: (Date) _____
Alcohol: Drinks/Week_____ Month _____
Coffee/Caffeine Drinks: Cups/Day_____
Eating Habits: (describe)_____

9 FAMILY HISTORY

Mother ☐ Living OR Cause of Death:_____
Father ☐ Living OR Cause of Death:_____
Significant family medical conditions (auto-immune, cancer, heart disease, etc): _____
_____

Are you Pregnant? No Yes Due Date _____