PATIENT REGISTRATION Today's Date________________________

Please complete all fields of the form. Indicate N/A for questions that do not apply. Thank you.

Patient:____Birth Date:___________________________

Address:____City:___________________________State:________Zip:___________

Home PH:____________________________Cell PH:____________________________Email:____________________________________

Occupation:_______________________________________Employer:____

Name of Spouse:____ # of Children_____________________________

Who is responsible for payment? ☐ Self ☐ Spouse ☐ Parent ☐ Other____

Insurance Company(s):____

Insured Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other____

Insured Name:____ Birth Date______________________________________

Purpose of this appointment and list your complaint(s):____

____

Date injury occurred or condition started: ____

How did injury/condition occur? ☐ Auto ☐ On the Job Other ____

What makes your condition feel **Better?** ____

____

What makes your condition feel **Worse?**____

____

Other Doctors seen for this condition:____

Have you been treated for any health condition in the last year? ☐ No ☐ Yes, Explain:_________________________________

Patient /Guardian Signature____

Patient____Date_________________________

PLEASE MARK EACH OF THE CONDITIONS BELOW THAT YOU ARE CURRENTLY EXPERIENCING.

Musculoskeletal System
- ☐ Low back pain/stiffness
- ☐ Mid back pain/stiffness
- ☐ Pain between shoulders
- ☐ Neck pain/stiffness
- ☐ Arm/wrist/elbow problems
- ☐ Shoulder problems
- ☐ Leg problems
- ☐ Swollen joints
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Muscle spasms
- ☐ Loss of motion/movement
- ☐ Chest pain

Eye & Ear
- ☐ Eye infection / inflammation
- ☐ Vision problems
- ☐ Ear pain / discharge
- ☐ Hearing loss/noises

Genitourinary System
- ☐ Bladder trouble
- ☐ Excessive urination
- ☐ Scanty urination
- ☐ Painful urination
- ☐ Discolored urine

Female ONLY
- ☐ Hormonal problems
- ☐ Breast problems
- ☐ Reproductive problems

Are you PREGNANT ?
☐ **YES** ☐ **NO**

Habits
- ☐ Cigarettes________pk/day
- ☐ Coffee or tea _____#cups/day
- ☐ Soda __________#/day
- ☐ Drug abuse
- ☐ Alcohol abuse

Gastrointestinal System
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficulty chewing
- ☐ Difficulty swallowing
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Vomiting blood
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Gallbladder problems
- ☐ Weight trouble/changes

Nose & Throat
- ☐ Nose pain/bleed/discharge
- ☐ Mouth/throat sore/hoarse
- ☐ Jaw / mouth problems
- ☐ Sinus problems

Nervous System
- ☐ Numbness
- ☐ Loss of feeling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Muscle jerking
- ☐ Convulsions
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Insomnia

Cardiovascular & Respiratory
- ☐ Chest / heart pain
- ☐ Varicose veins
- ☐ Heart problems
- ☐ Hard to breathe
- ☐ Lung problems

Circle area(s) of complaint.

Mark "X" on pain scale below.

Family History: **M = me** **F = family**
- ☐ Arthritis
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Epilepsy
- ☐ Heart Attack
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Concussion
- ☐ Asthma

☐ None Apply

Rate pain: **0 1 2 3 4 5 6 7 8 9 10**
None **Unbearable Pain**

Allergies: ☐ None ____

Medications: ☐ None ____

____

Over-the-Counter Medications (OTC) & Vitamins: ☐ None ____

____

List All Surgeries or Hospitalizations: ☐ None ____

____

Prior Illness or Injuries (Auto, Work, Etc.): ☐ None ____

____

Other health conditions you presently suffer from: ☐ None ____