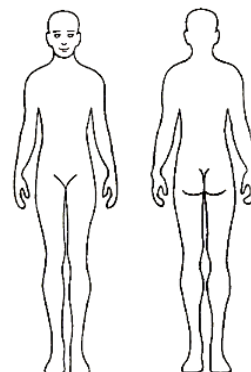


New Patient Registration

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	<input type="checkbox"/> Male <input type="checkbox"/> Female	Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Minor <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Cramps <input type="checkbox"/> Numbness <input type="checkbox"/> Aching <input type="checkbox"/> Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Throbbing <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling <input type="checkbox"/> Other				
How often do you have this pain?				
Is the pain constant or does it come and go?				
Does it interfere with your <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Recreation				
What activities are painful to perform? <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Lying down				



Health History

Patient Name

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

Hospital/Medicine

Have you had breast implant surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had knee or hip replacement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any implantable medical devices in your body?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any other surgeries or major medical conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Diagnostics

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

MRI X rays CT Nerve Conduction Studies