

PATIENT REGISTRATION

PATIENT INFORMATION

Date _____
SS#: _____ File # _____
Patient Name _____
E-mail _____
Address _____
City _____
State _____ Zip _____
Sex: Male Female Age _____
Birthdate: _____
Employer _____
Occupation _____
Spouse's Name _____
Spouse's Employer _____
Who referred you? _____
Name of family physician _____
May we contact them regarding your health? Yes No

INSURANCE INFORMATION

Who is responsible for this account? _____
Relationship to patient _____
Insurance Co.: _____
Group #: _____ ID# _____
Are you covered by additional insurance? Yes No
Secondary Insurance Co.: _____

ACCIDENT INFORMATION

Injury due to an accident? Yes No
If yes, Date of accident _____
Type of accident Auto Work Home Other
Have you made a report of your accident? Yes No
To Whom? Auto Insurance Employer Workers' Comp
 Other _____
Attorney Name (if applicable) _____

PHONE NUMBERS & EMERGENCY CONTACT

Home _____ Work _____ Cell _____ Best time to reach _____

Emergency Contact Information

Name _____ Relationship _____ Home _____ Work _____

PATIENT CONDITION (HPI)

Reason for visit _____

When did your symptoms start? _____ *(Please mark your areas of pain)*

How did your problem start? _____

Rate your pain level **today:** (please circle one)

0 1 2 3 4 5 6 7 8 9 10

No Pain

Severe Pain

Is your pain? Constant Frequent Occasional Intermittent
(100% of day) (75% of day) (50% of day) (25% of day)

Describe the pain: Sharp Dull ache Shooting Burning
 Throbbing Stabbing Numbness Tingling

Is your condition? Getting Better Staying the same Getting Worse

Does it interfere with? Work Sleep Recreation Daily Activity Nothing

What makes you worse? Sitting Standing Walking Bending Lying down

What makes you better? Nothing Rest Activity Heat Cold Medication

What tests have you had? X-rays MRI EMG Ultrasound Lab work

What treatment have you had? Drugs Nerve blocks PT Surgery

Has the treatment helped? Yes No

Have you ever had this problem before? Yes No

PATIENT NAME:

FILE #:

SOCIAL HISTORY

Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced / Separated <input type="checkbox"/> Widowed	Use of Alcohol <input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Moderately <input type="checkbox"/> Daily	Use of Tobacco <input type="checkbox"/> Never <input type="checkbox"/> Previously, but quit <input type="checkbox"/> Currently _____ Packs per day	Work Activity <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light labor <input type="checkbox"/> Heavy labor	Exercise Activity <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Strenuous
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PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS please check any that apply to you

Constitutional <input type="checkbox"/> None <input type="checkbox"/> Bad general health <input type="checkbox"/> Recent weight change <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Headaches Eyes <input type="checkbox"/> None <input type="checkbox"/> Eye disease/injury <input type="checkbox"/> Glasses or contact lens <input type="checkbox"/> Blurred / double vision Ear/Nose/Throat <input type="checkbox"/> None <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Vertigo <input type="checkbox"/> Sinus problems <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sore throat / voice change <input type="checkbox"/> Swollen glands Neurological <input type="checkbox"/> None <input type="checkbox"/> Seizures or Epilepsy <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Tremors <input type="checkbox"/> Stroke	Musculoskeletal <input type="checkbox"/> None <input type="checkbox"/> Joint Pain / Stiffness <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Fibromyalgia Cardiovascular <input type="checkbox"/> None <input type="checkbox"/> Chest pain / Palpitations <input type="checkbox"/> Dizziness / Fainting <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Swelling in hands / feet <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Heart attack <input type="checkbox"/> Congestive heart failure Gastrointestinal <input type="checkbox"/> None <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea/Vomitting <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> Blood in stools <input type="checkbox"/> Gall bladder problems <input type="checkbox"/> Liver problems <input type="checkbox"/> Ulcers	Urinary <input type="checkbox"/> None <input type="checkbox"/> Pain / Difficulty urinating <input type="checkbox"/> Blood in urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Kidney stones <input type="checkbox"/> Kidney problems Respiratory <input type="checkbox"/> None <input type="checkbox"/> Cough <input type="checkbox"/> Congestion <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia Psychologic <input type="checkbox"/> None <input type="checkbox"/> Anxiety / Depression <input type="checkbox"/> Mood Swings <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Memory loss Hematologic <input type="checkbox"/> None <input type="checkbox"/> Slow to heal after cuts <input type="checkbox"/> Bleed or bruise easily <input type="checkbox"/> Anemia <input type="checkbox"/> Enlarged glands	Endocrine <input type="checkbox"/> None <input type="checkbox"/> Excessive thirst / urination <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Skin becoming drier <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disorder Skin <input type="checkbox"/> None <input type="checkbox"/> Rash / Sores <input type="checkbox"/> Lesions <input type="checkbox"/> Breast pain or lump <input type="checkbox"/> Dermatitis / Eczema Allergic/Immune <input type="checkbox"/> None <input type="checkbox"/> Food allergies <input type="checkbox"/> Airborne allergies <input type="checkbox"/> Systemic Lupus <input type="checkbox"/> Cancer <input type="checkbox"/> HIV/AIDS FEMALES ONLY <input type="checkbox"/> I may be pregnant <input type="checkbox"/> I take birth control pills
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FAMILY HISTORY

	Living?		Rheumatoid Arth		Cancer		Diabetes		Heart Problems		Back Problems	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brothers/Sisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LIST HOSPITALIZATIONS AND SURGERIES

Falls _____

Fractures _____

Hospitalizations _____

Surgeries _____

MEDICATIONS

None

Nerve Pills Pain Killers Anti-Inflamm.

Muscle Relaxers Anti-Depressants

BP Medication Heart Meds.

Insulin Allergy Meds.

Other: _____

SUPPLEMENTS

None

Multi Vit/Min

Calcium

Glucosamine

Omega 3 Oils

Other: _____

ALLERGIES

1. _____

2. _____

3. _____

4. _____

5. _____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the clinic any changes in my medical status.

Signature of Patient or Parent of Minor: _____ Date: _____