Ashton CHIROPRACTIC CENTER

Chiropractic Registration and History

PATIENT INFORMATION

Date_____

Last Name:

First Name: Middle Initial:

Address:

City: State: Zip:

Home Phone Number:

Cell Phone Number:

Work Phone Number: May we call you at work?

◊ Single ◊ Married ◊ Partnered ◊ Divorced ◊ Widowed ◊ Minor

Sex: ◊M ◊F

Birthdate: Age:

E-Mail: May we send you e-mail correspondence?

Occupation: Patient Employer/School:

Who do we thank for referring you?

Who is responsible for this account? ◊Self ◊Insurance Company ◊Guardian (Name:)

Insurance company: ID#:

In Case of Emergency, Contact:

Name: Relationship:

Home Phone: Work Phone:

Primary Care Physician: Phone Number:

ACCIDENT INFORMATION

Is this condition due to an accident? ◊Yes ◊No Date of Accident:

Type of Accident: ◊Auto ◊Work ◊Home ◊Other

To whom have you made report of your accident? ◊Auto Insurance:

◊ Employer ◊ Worker Comp. ◊ Other

Claim # Attorney Name (if applicable)

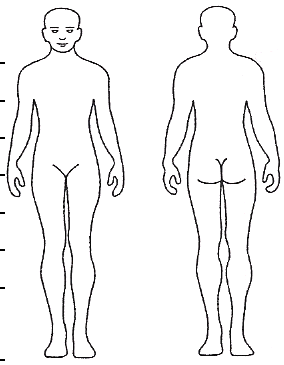
PATIENT CONDITION

Reason for your visit:

When did your symptoms appear?

Is this condition getting progressively worse? Yes No Don't Know

Mark an X on the picture where you have pain, numbness, or tingling.



Rate the severity of pain from 0 (no pain) to 10 (most pain you can image):

Type of pain: ◊Sharp ◊Dull ◊Throbbing ◊Numbness ◊Aching ◊Shooting ◊Burning ◊Tingling ◊Cramps ◊Stiffness ◊Swelling ◊Other (describe:)

Location of numbness or tingling

How often do you have these symptoms?

Is it constant or does it come and go?

Does it interfere with your: ◊Work ◊Sleep ◊Daily Routine ◊Recreation

Activities that are painful: ◊Sitting ◊Standing ◊Walking ◊Bending ◊Lying Down ◊Lovemaking

Are you experiencing any other symptoms in your body?

Name: **Date:**

HEALTH HISTORY

What treatment have you already had for your condition? ◊ Medications ◊ Surgery ◊ Physical Therapy
◊ Chiropractic Services ◊ None ◊ Other:

Name of other practitioners who have treated you for this condition:

Have you ever had chiropractic care?

Date of Last: Physical Exam: X-ray: in what area? Lab Work:

Spinal Exam: MRI, CT-Scan or Bone Scan: in what area?

Place a mark in the box to indicate if you have had any of the following:

◊ Arm/Hand Pain	◊ Dizziness	◊ Heart Disease	◊ Low Back problems	◊ Psychiatric Care
◊ Arthritis	◊ Emphysema	◊ Herniated Disc	◊ Multiple Sclerosis	◊ Rheumatoid Arthritis
◊ Bleeding Disorders	◊ Epilepsy	◊ Hepatitis	◊ Neck Pain/Stiffness	◊ Rheumatic Fever
◊ Breathing problems	◊ Fainting	◊ High Blood Pressure	◊ Osteoporosis	◊ Scoliosis
◊ Cancer	◊ Fibroids	◊ High Cholesterol	◊ Pacemaker	◊ Shoulder Problems
◊ Cataracts	◊ Glaucoma	◊ HIV/AIDS	◊ Parkinson's Disease	◊ Stroke
◊ Chicken Pox	◊ Gonorrhea	◊ Jaw Problems	◊ Pinched Nerve	◊ Thyroid Problems
◊ Chemical Dependency	◊ Headaches	◊ Kidney Disease	◊ Pneumonia	◊ TIA (Transient Ischemic Attack)
◊ Diabetes	◊ Hearing Difficulty	◊ Leg/Foot Problems	◊ Polio	◊ Tuberculosis
◊ Digestion problems	◊ Hernia	◊ Liver Disease	◊ Prosthesis	◊ Tumors/Growths
◊ Other conditions not listed above				◊ Venereal Disease

Exercise: ◊None ◊Moderate ◊Daily ◊Heavy Describe:

Work Activity: ◊Sitting ◊Standing ◊Light Labor ◊Heavy Labor

Habits: ◊Smoking _____ #Cigarettes or Packs/day How many years?_____ Were you ever a smoker?_____
◊Alcohol ____ # Drinks/week ◊ Caffeine Drinks ____ #Cups/Day ◊ High Stress Level Reason:

Women: Are you pregnant? ◊Yes ◊No Due Date: # of children:

Injuries/Surgeries Include a date and a description:
Falls:

Head Injuries:

Broken Bones:

Dislocations:

Surgeries:

Car Accidents:

Family Health History

Has anyone in your immediate family had the following conditions? (Including your grandparents):
◊Heart Disease ◊Stroke ◊Cancer ◊Diabetes Describe:
Any other diseases run in your family?

Medication:	For what condition?	Medication:	For what condition?

Vitamins/Herbs/Supplements:	Allergies:

Is there anything else you would like to share with your doctor?