

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)

- Unexplained Weight Gain or Loss (past 6 months) Yes No _____
- Night Pain Yes No _____
- Treated for Anxiety/Depression Yes No _____
- Excessive Alcohol Consumption / Illicit Drug Use Yes No _____
- 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 _____
- 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 _____