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Welcome!

NEW PATIENT REGISTRATION FORM:

PLEASE PRINT or TYPE

PERSONAL INFORMATION

Today's Date:

Name:

Birth Date:

Sex:

Address:

Email:

Referred by:

Home phone:

Work:

Cell:

Closest relative:

Address:

Phone:

Spouse/significant other:

Who lives at home?

Employer:

Occupation:

Medications/Supplements/Herbs/Home Remedy:

Allergies (Y,N): (please list)

Any medications?

DIET: (please describe)

Breakfast:

Lunch:

Dinner:

Exercise: (please describe)

Education:

Please list Surgeries, Serious Injuries, Fractures or illnesses, or hospitalizations:

Event

Date

Outcome

REASON FOR VISIT:

Explain:

Was there an initiating event?

What was different within 6 months before the onset of the problem:

LOCATION:

Where does it hurt?

(Using the symbols below, mark the areas of your body where you feel the described sensation. Include all affected areas.)

WORSE PAIN = WW ACHING = AA SHOOTING = SS PAIN = PP

NUMBNESS = NN BURNING = BB TINGLING = TT STABBING = ZZ

Right

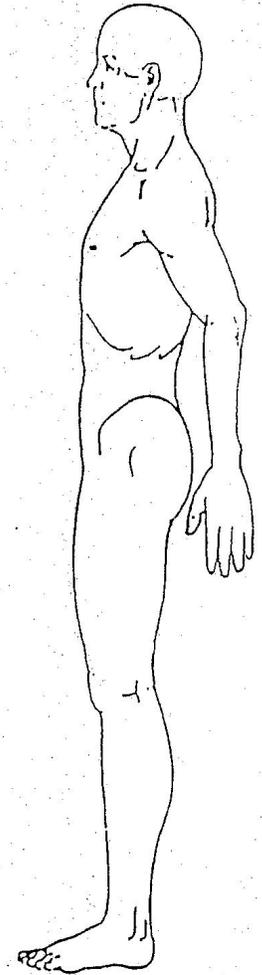
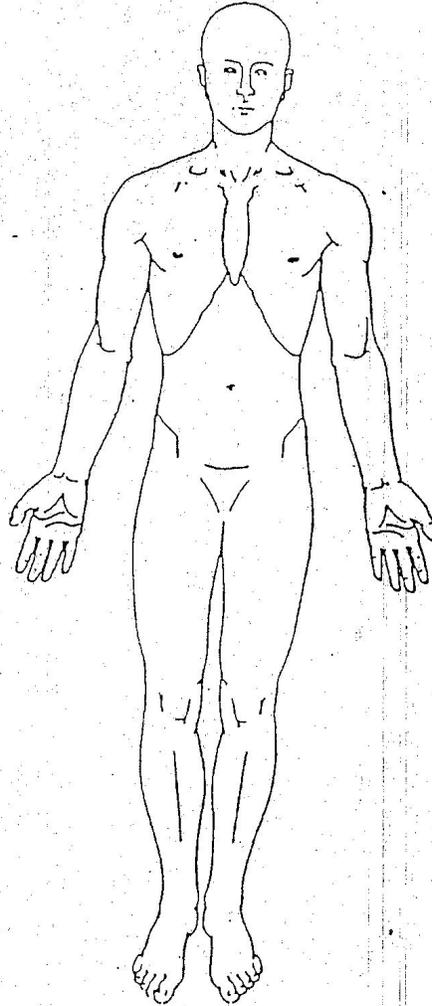
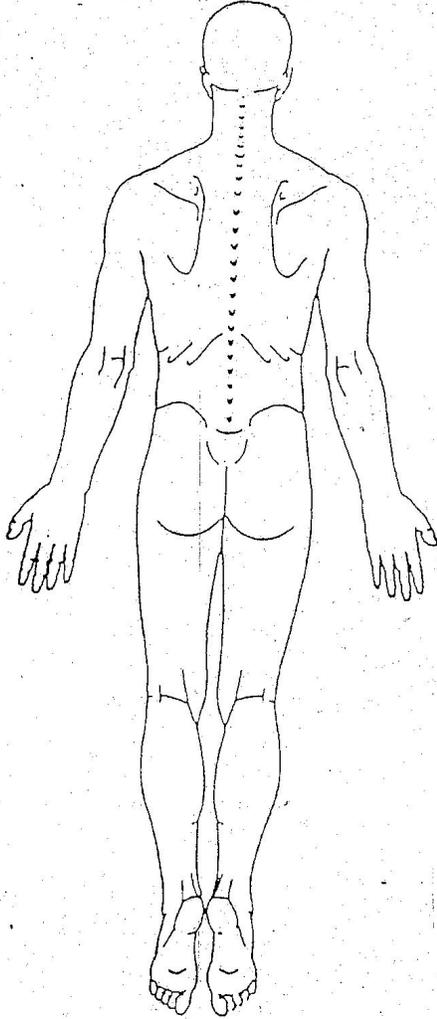
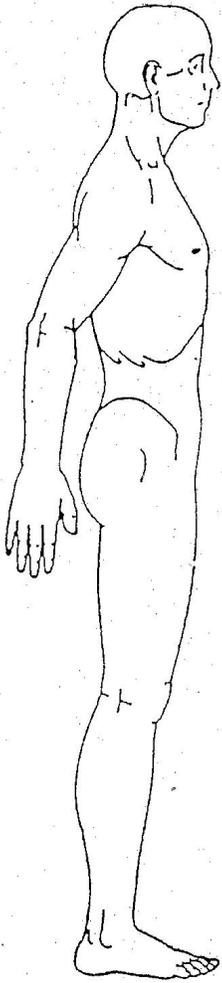
Left

Right

Right

Left

Left



Please illustrate where you feel discomfort.

INTENSITY: How bad is the pain? (Circle the number 0=no pain, 10 = worst pain possible)

NOW: 1 2 3 4 5 6 7 8 9 10

At ITS WORST: 1 2 3 4 5 6 7 8 9 10

AT ITS BEST: 1 2 3 4 5 6 7 8 9 10

ONSET: When did it start? (Most recent episode) _____

DURATION: (since initial event) _____

QUALITY: (circle all that apply)

1. Sharp dull burning deep ache pressure pins and needles other _____

TIMING: constant? ___ or intermittent? ___

Worse: morning? ___ afternoon? ___ evening? ___ night awakening? ___ Same all day? ___

WHAT MAKES IT WORSE? (circle all that apply)

Sitting Standing Walking Lying down Sustaining one position

Changing position (e.g. sit to stand, turn over in bed) other _____

WHAT MAKES IT BETTER? (circle all that apply)

Sitting Standing Walking Lying down Rest Stretching Exercise Heat Ice

Other _____

Have you had any of the following tests *for this or a similar problem*? Fill in dates.

(approx.) X-Ray?

MRI?

CT scan?

Bone Scan?

Myelogram?

Other?

Treatments for *this* problem?

Manipulation (osteopathic/chiropractic): When? _____ Result? _____

Medications: (types) _____ Result? _____

Injections: (types) _____ When? _____ Result? _____

Physical Therapy? When? _____ For how long? _____ Result? _____

Surgery? (types) _____ When? _____ Result? _____

DOES PAIN AFFECT YOUR (check all that apply):

Daily Routine?

How?

Mood?

How?

Recreation?

How?

Work?

How?

Sleep?

How?

Sex life?

How?

MEDICAL HISTORY

Check every condition you have had *ever* had.



Circle conditions currently present.

Write age of onset.

EYES

- Failing vision
- Double or blurred vision
- Squinting/"crossed" eyes
- Asymmetric gaze
- Eye pain
- Eye infections
- Lose placement reading
- Poor reading comprehension
- Eyestrain or fatigue from reading
- Headache from reading
- Glasses or contacts
- Monovision/progressive lens

ENT

- Decreased hearing
- Loud voice
- Snoring/mouth breathing
- Ringing/buzzing in the ears
- Ear infections
- Allergies/hay fever/runny nose
- Sinus problems,
- Nosebleeds
- Frequent sore throats
- Prolonged hoarseness
- Speech problems

CARDIOPULMONARY

- Asthma
- Emphysema
- Chronic cough
- Bronchitis
- Pneumonia
- Tuberculosis
- Shortness of breath on exertion
- Shortness of breath on lying flat
- Chest pains
- Heart murmurs
- Palpitations
- Swollen ankles
- Fainting spells
- Weight leg pain when walking
- Varicose veins/phlebitis

GI

- Eating disorder
- Recent loss of appetite
- Difficulty swallowing
- Heartburn
- Persistent nausea/vomiting
- Ulcers
- Chronic abdominal pain
- Recent change in bowel habits
- Diarrhea

Constipation

- Black or tarry stools
- Red blood in stools
- Hemorrhoids
- Diverticulosis
- Gallbladder trouble
- Jaundice/hepatitis
- Hernia

ENDO

- Chronic fatigue
- Recent weight loss
- Excessive weight gain
- Thyroid disease
- Cancer
- Diabetes

NEURO

- Convulsions/seizures
- Stroke
- Tremors
- Muscle weakness
- Numbness/tingling sensation
- Frequent headaches
- Clumsiness

MS

- Joint pain
- Scoliosis/kyphosis
- Arthritis
- Gout
- Cold or numb feet
- Involved in contact sports

DERM

- Rashes
- Psoriasis
- Eczema
- Hives
- Unusual moles

PSYCH/EMOTIONAL

- Difficulty sleeping
- Nightmares
- Nervousness/anxiety
- Stress
- Depression
- Memory loss
- Moodiness
- Phobias
- Nail biting/thumb sucking
- Bad temper/breath-holding
- Jealously

ILLNESSES

- Mumps
 - Measles
 - German measles
 - Chicken pox
 - Polio
 - Scarlet fever
 - Rheumatic fever
 - TB
 - Meningitis
- ### HABITS
- Alcoholism
 - Alcohol _____/day
 - Cigarettes _____/day
 - Coffee/tea _____ cups/day
 - Chocolate
 - Sugar
 - Other

HEME

- Anemia
- Malaria
- Bruise easily/bleeding
- Mononucleosis
- Unexplained lumps
- Fever/chills/excessive sweating

GU

- Bedwetting
- Bladder infections
- Kidney infection
- Pain on urination
- Poor control of urination
- Decreased force of urination
- Blood in urine
- Kidney stones
- Discharge from penis or vagina
- Sexually transmitted disease

FEMALE ONLY:

- Number of pregnancies _____
- Number of live births _____
- Number of miscarriages _____
- Method of birth control _____
- Age of onset of menses _____
- Flow: Light Moderate Heavy
- Length of flow _____
- Length of cycle _____
- Period not regular
- Pain/bleeding with intercourse
- PMS (medium to severe)

STRESS

Check any of the following that occurred
in your family the past year:
 Married Births Serious illness
 Divorced Deaths Separation
 Job loss Move Other _____

DENTAL
 Orthodontic treatment: age _____
 Dental extractions
 Crowns
 Root canal work
 Fillings

Bridgework
 Retainer/nightguard
 Gum problems
 TMJ

OTHER MEDICAL Conditions not listed above:

Major life trauma and or stressor (physical or emotional):

Family History:

Mother _____
Father _____
Maternal Grandmother _____
Maternal Grandfather _____
Paternal Grandmother _____
Paternal Grandfather _____