Align Spine Chiropractic & Wellness

Patient Registration/History

Patient Data: Date:_____/_____/_____

□ Mr. □ Mrs. □ Ms. □ Miss □ Dr. Sex: □ Male □ Female

First Name:_____ Middle Initial: _____ Last Name: _____

Address line: _____

City: _____ State: _____ Zip Code:_____

Cell Phone: (_____) _____ - _____ Home Phone: _____

Date of Birth:_____/_____/___ Email: _____

Social Security #: _____ - _____ - _____ Marital Status: □ Single □ Married □ Other

(Medicare only) # of children :_____

Emergency Contact: _____ Relationship: _____ Phone#: _____

Insurance:

Subscriber's name: _____ Date of Birth: _____

Are you the subscriber: □ Yes If not: □ Dependent/Child □ Spouse ID #_____

Insurance Company: _____ Group #: _____

Secondary Insurance:

Insurance Company: _____ ID #: _____

Employer Data :

Employment Status: □ Employed □ Full time student □ Part time student □ Unemployed □ Other

Name: _____

Address line: _____

City: _____ State: _____ Zip Code:_____

Are your present problems due to an injury? □ No □ Yes □ On the Job □ Auto Accident □ Personal Injury

□ Other _____

Has the accident been reported? □ No □ Yes □ To Employer □ Auto Carrier □ Other _____

Are you now or have you ever been disabled? (Work or Service) □ No □ Yes When? _____

Why?_____

Have you retained an attorney? □ No □ Yes Name/Address:_____

How did you hear about our clinic?

□ Attorney □ Clinic Website □ Yellow Pages □ Brochure □ Flyer

□ Newspaper Ad □ Direct Mail Ad □ Radio □ TV Commercial □ Employer

□ Radio □ Sign on Building □ Health Class □ Physician _____

□ Family Member _____ □ Friend _____

□ Other _____

Symptoms:

** Circle if you have any of these conditions.

General

Bronchitis
Chills
Convulsions
Fever
Nervousness
Fainting
Dizziness
Fatigue
Headache
Neuralgia
Depression
Wheezing
Sweats
Loss of sleep
Difficulty walking
Uncoordinated walking

Gastro-Intestinal

Diarrhea
Hemorrhoids
Jaundice
Liver Trouble
Excessive Eating
Gall Bladder Trouble
Constipation
Abdominal pain
Belching/gas/bloating
Nausea
Rectal bleeding
Indigestion
Vomiting
Vomiting Blood
Stomach Pain
Poor appetite
Poor digestion
Excessive thirst

Ears/Eyes/Nose/Throat

Hoarseness
Difficulty swallowing
Bleeding gums
Sore throat
Tonsilitis
Persistent cough
Frequent colds
Enlarged thyroid
Poor Vision
Pain in eyes
Crossed Eyes
Double Vision
Irregular eye movements
Speech difficulty
Deafness
Ear noises
Earache
Ear discharge

Respiratory

Spitting Phlegm
Spitting blood
Chronic cough
Chest pain
Difficulty breathing

Genito-Urinary

Blood in urine
Bed wetting
Painful urination
Frequent urination
Kidney infection
Prostate Enlargement

Skin or Allergies

Skin eruptions
Itching
Sensitive Skin
Boils
Bruising easily
Dryness
Eczema

Muscle/Joints/Bones

Stiff neck
Swollen Joints
Foot trouble
Spinal Curvature
Tremors/twitching
Arms trouble
Backache
Low blood pressure
Pain between shoulders

Cardiovacular

Pain over heart
Poor circulation
Rapid heart rate
Slow heart rate
Swollen ankles
Varicose veins
Previous heart trouble

Women Only

Irregular cycle
Miscarriage
Painful periods
Hot flashes
Lump in breast
Abnormal mammogram
Abnormal pap smear Painful tailbone

Health Conditions:

** Circle if you have/had these conditions.

Anorexia	Alcoholism	Rheumatoid Arthritis
Bulimia	Diabetes Mellitus	Juvenile Rheumatoid Arthritis
Diabetes Insipidus	Chicken pox	Shingles
Anxiety	Emphysema	Epilepsy
Gout	Hernia	Herniated disc
Asthma	High Blood Pressure	High Cholesterol
Lupus erythmatosus	SLE	Lyme Disease
Multiple Sclerosis	Osteoporosis	Pacemaker
Polio	Stroke	Tuberculosis
Urinary Tract infection	Appendicitis	Pneumonia
Influenza	Pleurisy	Venereal Disease
Transient ischemic attack (TIA)	Mumps	Measles
Rheumatic Fever	Migraines	Cancer
Whooping cough	Bleeding disorder	Anemia

Surgeries:

Date	Date	Date	Date
_____ tonsillectomy	_____ gall bladder	_____ tubes in ears	_____ sinus
_____ appendectomy	_____ back operation	_____ female organs	_____ hernia
_____ colorectal surgery	_____ heart surgery	_____ stomach	_____ thyroid
_____ other _____	_____ other _____	_____ other_____	

Allergies:

□ Environmental
□ Latex
□ Medications
□ Seasonal

Social History:

□ Caffeine _____cups/day
□ Alcohol _____drinks/wk
□ Tobacco _____packs/wk
□ Exercise _____hr/wk

Family History:

□ Arthritis □ Cholesterol □ psychiatric
□ Heart Problems □ Diabetes □ Other_____
□ Thyroid □ Stroke _____
□ Cancer □ Kidney disorders _____

Medications:

** List any medications that you are currently taking.

Occupational Activities:

□ Sitting	never	moderately	frequently	□ Standing	never	moderately	frequently
□ Walking	never	moderately	frequently	□ Bending	never	moderately	frequently
□ Light lifting	never	moderately	frequently	□ Operate machinery	never	moderately	frequently
□ Heavy lifting	never	moderately	frequently	□ Overhead work	never	moderately	frequently
□ Reaching	never	moderately	frequently				

Chief Complaint (s):

Use the key below to indicate on the body diagram where you are experiencing the following symptoms:

X = sharp / = dull ache ~ = numbness ^ = tingling * = deep-boring + = throbbing

S = stiffness 0 = burning

Describe your symptoms:_____

_____

_____

_____

_____

_____

_____

When did you symptoms start? _____ /_____ /_____

How did your symptoms start?_____

_____

_____

_____

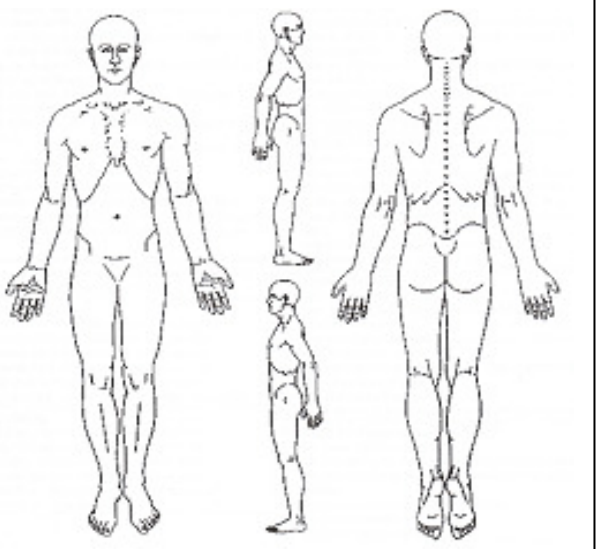
_____

_____

How often do you experience the symptoms during the day? □ <25% □ 25-50% □ 51-75% □ 76-100%

Have the symptoms been: □ getting worse □ getting better □ unchanged

PAIN DIAGRAM



Pain scale 0 -10 (0 = no pain, 10 = excruciating pain): circle one

0 1 2 3 4 5 6 7 8 9 10

What makes the condition(s) *better*? □ heat □ ice □ pain killers □ rest □ movement □ bending forward □ leaning back □ sitting □ standing □ walking □ stretching □ twisting □ walking upstairs □ walking downstairs □ other _____

What makes the condition(s) *worse*? □ heat □ ice □ rest □ sitting □ movement □ twisting □ lifting □ bending forward □ coughing □ sneezing □ standing □ walking □ stretching □ leaning back □ walking upstairs □ walking downstairs □ other _____

Time of day when worse: □ AM □ afternoon □ PM □ disrupts sleep

The complaint radiates into: □ shoulder □ upper arm □ forearm □ fingers □ buttock □ hip □ back of thigh □ front of thigh □ calf □ toes □ there is no radiation

Have you seen a professional for this in the past? □ No □ Yes _____

Result: _____

(over)