Middleton Chiropractic Registration and History

Full Name____

Preferred Name__________________________ **Social Security #**_________________

Date of Birth____________ **Age**______ **Email**________________________________

Telephone Home________________ **Work**________________ **Cell**_______________

Street Address____

City______________________ **Zip**_______________

Emergency Contact_____________________ **Telephone**________________________

Medical Dr. /Clinic____

Employer____________________________ **Type of Work**_______________________

How many years have you worked in the industry? _____________________________

Whom may we thank for referring you?______________________________________

Have you ever been to a Chiropractor before? Yes__ No__ Date of last visit_________

Patient Condition

Reason for visit____

When did you first notice symptoms? ____

Is condition getting worse? ____

Type of pain: Sharp__ Dull__ Throbbing__ Numbness__ Aching__ Shooting__
Burning__ Tingling__ Cramps__ Stiffness__ Swelling__ Other__________

How often do you have this pain? __________**Is it constant or comes and goes?** ______

Does it interfere with your Work__ Sleep __ Daily Routine __ Recreation __

Activities/movements that are painful to perform Sitting __ Standing __ Walking__
Bending __ Lying Down __

Health History

What treatments have you already received for your condition? Medication__ Surgery__ Physical Therapy__ Chiropractic Services__ None__ Other_________________________

When was you last visit to your PCP? ____
When was your last spinal X-ray? ____

Have you had any of the following diseases? Arthritis__ Gout__ Epilepsy__ Cancer__ Eczema__ Polio__ Rheumatic Fever__ Multiple Sclerosis__ Shingles__ Concussion__ Osteoporosis__ Asthma__ Thyroid Disease__ Tuberculosis__ Heart Disease__ Diabetes__ Anemia__ Pleurisy__ Emphysema__ Bone Fractures__________________

Please describe any current medical complaints that you are experiencing and were not covered by this questionnaire?____
____

How often do you exercise? None__ Moderate__ Daily__ Heavy__

What is your work activity like? Sitting__ Standing__ Light Labor__ Heavy Labor__

What are your habits like? Smoking__ Packs/Day________________________________
Alcohol__ Drinks/Week_________________________________
Coffee/Caffeine Drinks__ Cups/Day____________________

Are you Pregnant? Yes__ No__ Due date____

How many pillows do you sleep with? ____

Have you had any major accidents or falls? Please Explain. ________________________
____

Have you had any surgeries? Please Explain. ____________________________________

Are you currently involved in any legal proceedings as a result of injuries sustained in an accident? ____

Medications ____

Signature

____ Date________________________
If under 18, legal guardian must sign