PATIENT REGISTRATION

Complete Performance Chiropractic

PATIENT INFORMATION

Date _____

Patient Name _____

Address _____

City _____

State _____ Zip _____

Sex: ☐ Male ☐ Female SS#: _____

Birthdate: _____ Age _____

Occupation _____

Employer _____

Spouse's Name _____

Primary Care Physician: _____

May we contact them regarding your health? ☐ Yes ☐ No

How were you referred to office? _____

CONTACT INFORMATION

Cell _____

Home _____

Work _____

Email _____

Emergency contact _____

Relationship _____ Phone _____

INSURANCE/ACCIDENT INFORMATION

Name of Insurance: _____

ID #: _____ Group #: _____

Is injury due to an accident? ☐ Yes ☐ No

If yes, Date of accident _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

☐ Auto Insurance ☐ Employer ☐ Workers' Comp

Attorney Name (if applicable) _____

ELECTRONIC HEALTH RECORD REPORTING (Per Federal Requirements)

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ White ☐ Black/African Amer. ☐ Amer. Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Other

Preferred contact method: ☐ Call cell ☐ Text cell ☐ Call home ☐ Call work ☐ Email ☐ Fax (_____)

PATIENT CONDITION (HPI)

Major complaints: _____

_____

When did your symptoms start? _____

How did this episode start? _____

Have you had it before? ☐ Yes ☐ No. If yes, how long? _____

Is your pain? ☐ Constant (100% of day) ☐ Frequent (75% of day) ☐ Occasional (50% of day) ☐ Intermittent (25% of day)

Describe the pain: ☐Sharp ☐Dull ache ☐Shooting ☐Burning ☐Throbbing ☐Stabbing ☐Numbness ☐Tingling

My condition is: ☐ Getting Better ☐ Staying the same ☐ Getting Worse

It interferes with: ☐Work ☐Sleep ☐Recreation ☐Daily Activity

It's worse when: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Laying

It's better with: ☐Nothing ☐Rest ☐Activity ☐Heat ☐Cold ☐RX

Tests I've had: ☐X-rays ☐MRI ☐CT ☐Ultrasound ☐Lab work

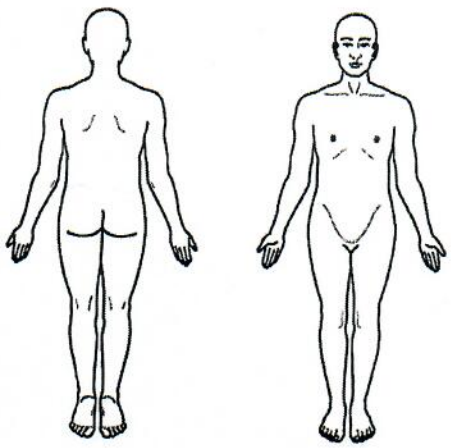
What treatment have you had: ☐RX ☐Nerve blocks ☐PT ☐Surgery

Did the treatment help? ☐Yes ☐No

I'm interested in: ☐ Chiropractic ☐ Acupuncture ☐ Laser Therapy ☐ Spinal Decompression

☐ I prefer to have doctor choose most beneficial treatment

(Please mark your areas of pain)



Rate your pain level **today:** (please circle one)

0 1 2 3 4 5 6 7 8 9 10

No Pain → → → *Severe Pain*

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Complete Performance Chiropractic

SOCIAL HISTORY

Marital Status	Use of Alcohol	Use of Tobacco	Work Activity	Exercise Activity
☐ Single	☐ Never	☐ Never smoked	☐ Sitting	☐ None
☐ Married	☐ Occasionally	☐ Former smoker	☐ Standing	☐ Light
☐ Divorced / Separated	☐ Moderately	☐ Smoke some days	☐ Light labor	☐ Moderate
☐ Widowed	☐ Daily	☐ Every day smoker	☐ Heavy labor	☐ Strenuous

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS *please check ☑ any that apply to you, or ☑ NONE*

Musculoskeletal ☐ None
- ☐ Headaches
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Lower back pain
- ☐ Sacroiliac pain
- ☐ Rib pain
- ☐ Joint pain
- ☐ Muscle spasm
- ☐ Fibromyalgia
- ☐ Arthritis

Constitutional ☐ None
- ☐ Recent weight gain / loss
- ☐ General fatigue
- ☐ Fever
- ☐ Chills

Cardiovascular ☐ None
- ☐ Chest pain / Angina / Palpitations
- ☐ Shortness of breath
- ☐ High blood pressure
- ☐ Heart attack / Congestive heart failure
- ☐ Pacemaker

Hematology ☐ None
- ☐ Anemia
- ☐ Leukemia
- ☐ Easy bruising

Neurological ☐ None
- ☐ Numbness / Tingling
- ☐ Seizures / Epilepsy / Dizziness
- ☐ Stroke
- ☐ Tremors / Weakness

Respiratory ☐ None
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sleep apnea

Eyes/Ears/Nose/Throat ☐ None
- ☐ Eye disease / injury
- ☐ Blurred / Double vision
- ☐ Hearing disorders
- ☐ Vertigo
- ☐ Sinus problems
- ☐ Swallowing difficulty

Gastrointestinal ☐ None
- ☐ Nausea
- ☐ Gastric reflux
- ☐ Ulcers
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Pancreatitis
- ☐ Gall bladder disorders

Genitourinary ☐ None
- ☐ Kidney stones / Kidney disorders
- ☐ Painful urination
- ☐ Loss of bladder control

Endocrine ☐ None
- ☐ Diabetes
- ☐ Hypothyroid
- ☐ Hyperthyroid

Allergic / Immune ☐ None
- ☐ Allergies
- ☐ Dermatitis / Eczema / Rash
- ☐ Shingles / Lesions
- ☐ Rheumatoid Arthritis
- ☐ Systemic Lupus
- ☐ HIV / AIDS
- ☐ Cancer / Tumors / Lymphoma

Psychological ☐ None
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Drug / Alcohol Dependence

FEMALES ONLY ☐ None
- ☐ Pregnancy
- ☐ Birth control pills
- ☐ Hormonal Replacement

FAMILY HISTORY

	Living?		Rheum Arthritis		Heart Problems		Diabetes		Cancer		Lupus		Back Problems	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brothers/Sisters	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

HOSPITALIZATIONS AND SURGERIES

Fractures _____ Hospitalizations _____

Surgeries _____

PRESCRIBED MEDICATIONS

Name of drug	Quantity	Strength	Dose form (tablet, etc)	Instructions (1/day, etc)

Are you allergic to any medications? ☐ No ☐ Yes (if yes, list name and symptoms) _____

List any vitamins or supplements you take _____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the clinic any changes in my medical status. I understand that I am ultimately responsible for my bill regardless of insurance payment or not. I agree to give a minimum of 24 hours notice if changing or cancelling an appointment or I will be charged $25 before my next appointment can be scheduled.

_____
Patient Name

_____ _____ _____
Signature of Patient (or Parent of Minor) **Name of Parent** **Date**