

**PATIENT REGISTRATION AND HISTORY**

Patient Name \_\_\_\_\_ SS# \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Ph (\_\_\_\_\_) \_\_\_\_\_ Work Ph (\_\_\_\_\_) \_\_\_\_\_ Cell Ph (\_\_\_\_\_) \_\_\_\_\_  
 Email Address \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female Marital Status: S M D W  
 Referred to our office by: \_\_\_\_\_

Our office is HIPPA compliant and our manual is available for your review. We are required by law to inform you that your personal information will be kept secure and confidential. However, your personal information may be released to your insurance company and/or your primary care physician and/or our collection agency to aid in treatment or receive payment of treatment. All payments made by insurance companies will be sent directly to Body Needs Chiropractic or turned over to this clinic within a reasonable time. You will be responsible for any charges not covered by insurance. Delinquent accounts may be charged interest of 1½% per month and you will be responsible for any and all collection fees if applicable. By signing below I acknowledge that I have read this statement and agree to its terms.

\_\_\_\_\_  
 Signature of patient or legal guardian

\_\_\_\_\_  
 Date

Please indicate your exposure to the following complimentary therapies:				What are you health goals?	
Chiropractic Care	Yes No	If yes, date of last visit	/ /	____ remove pain	
Nutritional Supplementation	Yes No	Acupuncture	Yes No	____ gain more energy/stamina	
Massage Therapy	Yes No	Homeopathy	Yes No	____ restore health/reduce illness	
Medicinal Herbs	Yes No	Other:		____ achieve optimal wellness	

Primary Complaint (reason for visit): \_\_\_\_\_

Indicate areas of pain on the chart below:

Numbness	===	Knot	●
Dull Ache	OOO	Burning	XXX
Sharp/Stabbing	///	Pins, Needles	+++
Other	^^^		

Is this condition due to an accident?  Yes  No Date: \_\_\_\_\_  
 Type of Accident: Auto Work Other

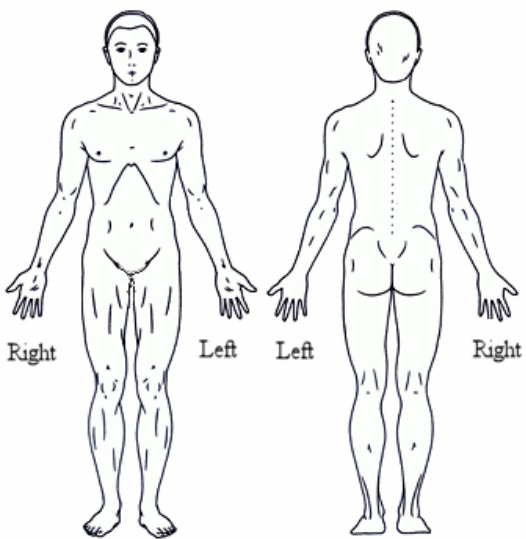
Do you have a diagnosed medical condition(s)?  Yes  No  
 If so, please list: \_\_\_\_\_

Are you currently under medical care for the pain/symptoms?  Yes  No  
 If so, name of physician/practitioner: \_\_\_\_\_

Since the onset, the pain/symptoms have been:  Better  Worse  Same

Is this condition worse at certain times of the day/night?  Yes  No  
 If so, please describe: \_\_\_\_\_

Do you have pain that shoots, radiates, or is intermittent?  Yes  No  
 If so, please describe: \_\_\_\_\_



Please rate the severity of your pain:  
 (worst) 1 2 3 4 5 6 7 8 9 10 (best)

**What activities worsen?**

<input type="checkbox"/> Sleeping	<input type="checkbox"/> Bending
<input type="checkbox"/> Walking	<input type="checkbox"/> Reaching
<input type="checkbox"/> Running	<input type="checkbox"/> Driving
<input type="checkbox"/> Eating	<input type="checkbox"/> Stretching
<input type="checkbox"/> Other _____	

**This condition is interfering with?**

<input type="checkbox"/> Sleeping	<input type="checkbox"/> House chores
<input type="checkbox"/> Work	<input type="checkbox"/> Exercise
<input type="checkbox"/> Hobbies	<input type="checkbox"/> Relationships
<input type="checkbox"/> Eating	<input type="checkbox"/> Driving
<input type="checkbox"/> Other _____	

**Patient History** (Please circle Yes or No for each of the following and provide commentary as necessary)

Current/Past Health Habits (check <input type="checkbox"/> for past use):			Patient Comment	Doctor's Comment (Office Use)
Drink alcohol	<input type="checkbox"/> Past	Y N	How often?	
Drink coffee	<input type="checkbox"/> Past	Y N	How often?	
Drink water	<input type="checkbox"/> Past	Y N	How much?	
Daily sweets	<input type="checkbox"/> Past	Y N	How often?	
Sugar substitutes	<input type="checkbox"/> Past	Y N	How often?	
Dieting or cleansing	<input type="checkbox"/> Past	Y N	How often?	
Smoke cigarettes	<input type="checkbox"/> Past	Y N	How often?	
Chew tobacco	<input type="checkbox"/> Past	Y N	How often?	
Recreational drug use	<input type="checkbox"/> Past	Y N	How often?	
Exercise regularly	<input type="checkbox"/> Past	Y N	How often?	
Occupational stress	<input type="checkbox"/> Past	Y N	physical emotional	
Relationship stress	<input type="checkbox"/> Past	Y N	physical emotional	
Drive long distances	<input type="checkbox"/> Past	Y N		
Wear shoe lift/orthotics	<input type="checkbox"/> Past	Y N		
Sleep position	Indicate Position		Side Stomach Back	
Current/Past Health History (check <input type="checkbox"/> for past use):			Patient Comment	Doctor's Comment (Office Use)
Dental/gum problems	<input type="checkbox"/> Past	Y N		
Eye/vision problems	<input type="checkbox"/> Past	Y N		
Hearing problems	<input type="checkbox"/> Past	Y N		
Headaches	<input type="checkbox"/> Past	Y N		
Tinnitus/ringing in the ears	<input type="checkbox"/> Past	Y N		
Depression/mental illness	<input type="checkbox"/> Past	Y N	Family History Y N	
TMJ/locking of the jaw	<input type="checkbox"/> Past	Y N		
Broken bones	<input type="checkbox"/> Past	Y N		
Torn ligaments	<input type="checkbox"/> Past	Y N		
Heartburn/reflux	<input type="checkbox"/> Past	Y N		
High/low blood pressure	<input type="checkbox"/> Past	Y N		
High cholesterol	<input type="checkbox"/> Past	Y N		
Diabetes	<input type="checkbox"/> Past	Y N	Family History Y N	
Hypoglycemia	<input type="checkbox"/> Past	Y N		
Asthma	<input type="checkbox"/> Past	Y N		
Seasonal allergies	<input type="checkbox"/> Past	Y N		
Respiratory infections	<input type="checkbox"/> Past	Y N		
Sinus infections	<input type="checkbox"/> Past	Y N		
Heart attack	<input type="checkbox"/> Past	Y N	Family History Y N	
Stroke	<input type="checkbox"/> Past	Y N	Family History Y N	
Mono/other serious virus	<input type="checkbox"/> Past	Y N		
Cold hands/feet	<input type="checkbox"/> Past	Y N		
Weight loss/gain	<input type="checkbox"/> Past	Y N		
Hyper/Hypothyroidism	<input type="checkbox"/> Past	Y N		
Arthritis	<input type="checkbox"/> Past	Y N	Family History Y N	
Colitis/Crohn's/IBS	<input type="checkbox"/> Past	Y N		
Frequent constipation	<input type="checkbox"/> Past	Y N		
Frequent diarrhea	<input type="checkbox"/> Past	Y N		
Irregular menses	<input type="checkbox"/> Past	Y N		
Menopause	<input type="checkbox"/> Past	Y N		
Miscarriage/infertility	<input type="checkbox"/> Past	Y N	Family History Y N	
Sleep problems	<input type="checkbox"/> Past	Y N		
Cancer	<input type="checkbox"/> Past	Y N		

