

Palmetto Clinic of Chiropractic
Patient Registration

Patient Contact

Title: Mr./Mrs./Ms./Dr./Rev./Rank _____ Date _____
Last Name _____ First Name _____ M.I. _____ Nickname _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Mobile Phone _____
Work Phone _____ E-Mail _____

Patient Personal

Age _____ Date of Birth _____ Gender: Male Female
Social Security # _____ Drivers License #/State _____
Employer Name _____ Occupation _____
Marital Status: Single Married Widowed Separated Divorced
Spouse Name _____ Children(names, ages) _____

Emergency Contact

Name _____ Relationship _____
Home Phone _____ Mobile Phone _____ Work Phone _____

Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend or Family Member Name _____

Yellow Pages Website Presentation Sign Newspaper Other _____

Do you have health insurance? Yes No Company? _____

Are you here because you were in an auto accident? Yes No

Are you here because you were injured at work? Yes No

Who is your:

Primary Care Physician _____ Last Visit _____

Massage Therapist _____ Last Visit _____

Dentist _____ Last Visit _____

Gynecologist _____ Last Visit _____

Other _____ Last Visit _____

Patient Case History

I. Health Complaints

I have no health complaints, I am interested in prevention and health maintenance (skip to section II)

What is your **primary** complaint? _____

List other health complaints on the following lines:

2 _____ 3 _____
4 _____ 5 _____
6 _____ 7 _____

How long have you been experiencing the **primary** complaint? _____

How does the **primary** complaint feel? dull sharp numb tingling burning spasm other _____

How often do you experience the **primary** complaint? constantly daily weekly monthly yearly

What makes your **primary** complaint better? _____ worse? _____

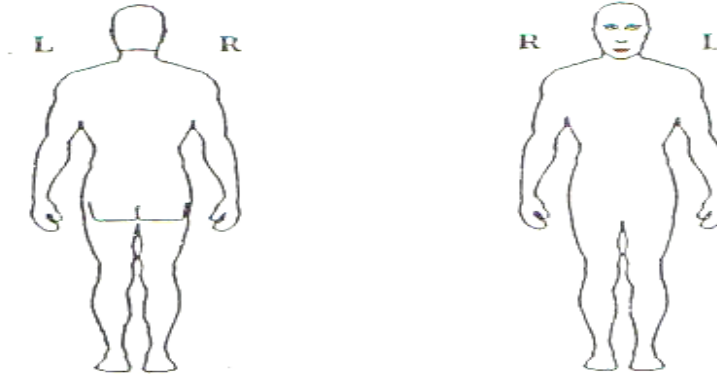
Have you missed any work or school because of your **primary** complaint? yes no

How does your **primary** complaint affect you at home/work/school? _____

Have you had any prior treatment for your **primary** complaint? _____

What do you believe is causing your **primary** complaint? _____

Please mark the areas of all of your complaints on the diagrams to the right.



II. Health History

How often do you use tobacco? never daily weekly monthly

How many servings of alcohol do you drink each week? 0 1-2 3-5 6-9 10-20 >20

How many servings of coffee do you drink each week? 0 1-2 3-5 6-9 10-20 >20

How many servings of soda do you drink each week? 0 1-2 3-5 6-9 10-20 >20

How many ounces of water do you drink each day? 0 1-10 11-20 21-40 41-60 61+

How many times do you eat per day? 1 2 3 4 >5

How many servings of fruits and vegetables do you eat per day? 0 1-2 3-5 6-9 >9

How often do you exercise? daily 3x's/week 2x's/week 1x/week I don't exercise

How long do your workouts last? <30 minutes 30 minutes 1 hour >1 hour

What are your exercise activities? (mark all that apply)

- walking swimming weight lifting stretching/flexibility resistance bands
 running/treadmill/rowing yoga/pilates group exercise classes other _____

Are you pregnant? Yes No If yes, how many weeks? _____

Do you have pain when you breathe? yes no

Have you ever worked around toxic chemicals, in a coal mines or around asbestos? yes no

Do you cough often? yes no Any Mucus? yes no If yes, what color? _____

Have you ever been diagnosed with having problems with any of the following (if yes to any, please indicate when)?

- | | | | | |
|--------------------------------------|------------------------------------|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Weight | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Digestion | <input type="checkbox"/> Liver | <input type="checkbox"/> Spine/Back |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Lungs | <input type="checkbox"/> Circulation | <input type="checkbox"/> Pancreas |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Fainting | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Stomach | <input type="checkbox"/> Nervous System |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Ovaries | <input type="checkbox"/> PMS | <input type="checkbox"/> Spleen | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Breast | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Colon | <input type="checkbox"/> Constipation | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Edema | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Tumors | _____ |

IV. Medications and Supplements

Are medications (prescription or over-the-counter) necessary for you to have relief and/or to function? yes no

Do you use an inhaler or nebulizer? yes no What type? _____ How often? _____

Please list any medications (prescription and over the counter) and/or supplements you are currently taking and why:

- | | |
|---------|---------|
| 1 _____ | 5 _____ |
| 2 _____ | 6 _____ |
| 3 _____ | 7 _____ |
| 4 _____ | 8 _____ |

III. Hospitalization, Surgeries and Injuries

Do you have a pacemaker? yes no

Have you had knee or hip replacement surgery? yes no

Have you had breast implant surgery? yes no

Do you have any other implantable medical device in your body? yes no

Please list any hospitalizations, surgeries, auto accidents, job injuries, sports injuries or injuries that you have had:

Date	Description
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____

V. Genetic History

Have any of your blood relatives had any of the following conditions? If yes, please list who.

Heart Disease _____	Stroke _____
Cancer _____	Arthritis _____
Diabetes _____	Auto-Immune Disease _____

What services interest you? (mark all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Injury Prevention | <input type="checkbox"/> Nutritional and supplement counseling | <input type="checkbox"/> Patient education classes |
| <input type="checkbox"/> Balance and coordination training | <input type="checkbox"/> Spinal and body alignment | <input type="checkbox"/> Treatment for pain |
| <input type="checkbox"/> Range of motion, mobility, or flexibility therapy | <input type="checkbox"/> Strengthening and stamina exercise | <input type="checkbox"/> Other _____ |

Patient or guardian signature

Date