The Health Connection
CHIROPRACTIC • ACUPUNCTURE • MASSAGE

New Patient Registration

____
Today's Date (MM/DD/YYYY)

______________________________ Gender ◯ Male ◯ Female ______________________________
Last Name Social Security Number

First Name ____________ Middle Name (Or Initial) ____________ Date of Birth (MM/DD/YYYY) ____________ Height ____________

Address ______________________________

Marital Status
◯ Single ◯ Married
◯ Divorced
◯ Widowed ◯ Separated

Weight ____________

City ____________ State ____________ ZIP/Postal Code ____________

Home Phone ____________ Cell Phone ____________ Spouse's Name ____________ Spouse's Birth Date ____________

E-Mail Address ______________________________

<u>As a Courtesy,</u> we utilize TEXT MESSAGE or EMAIL for appointment reminders. Please choose one:

◯ Text Message (Phone Number) ________________________Carrier:__________________________ ◯ Email address listed above

Initials________ I grant permission to be called, emailed, or receive text messages to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.

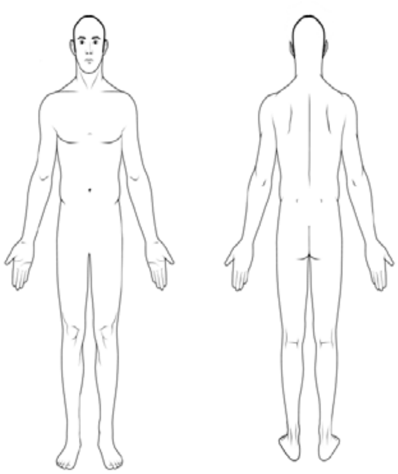
Emergency Contact ______________________________ Relationship & Phone ______________________________

Your Occupation ______________________________ Your Employer ______________________________

Primary Physician ______________________________

Whom may we thank for referring you? ______________________________

1. **What symptoms prompted you to seek care today**______________________________
2. **When did these symptoms start? How did they start?** ______________________________



3. Quality of Symptom (What does it feel like?)

◯ Numbness ◯ Heavy
◯ Tingling ◯ Sharp
◯ Tightness ◯ Burning
◯ Dull ◯ Shooting
◯ Aching ◯ Throbbing
◯ Cramps ◯ Stabbing
◯ Other

4**. Intensity** (How extreme)

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Absent Uncomfortable Agonizing

5. **Duration & Timing** (How often)

◯ Constant ◯ Comes and Goes

6. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)______________________________

7. **Aggravating or Relieving Factors** (What makes it better or worse, such as time of day, movements, activities, etc.)

What tends to lessen the problem? ______________________________

What tends to worsen the problem? ______________________________

Modified: 08/07/2017

8. **Prior Interventions**

(What have you done to relieve the symptoms?)

◯ Prescription medication ◯ Ice

◯ Over-the-counter drugs ◯ Heat

◯ Other___________________________

9. **What else should we know about your current condition?**

____

____

9. **Review of systems** (Identify any changes since your most recent evaluation with us)

	Current	Past	None
Musculoskeletal System- osteoporosis, arthritis, neck pain, back problems, poor posture	◯	◯	◯
Neurological System- anxiety, depression, headache, dizziness, pins & needles, numbness	◯	◯	◯
Cardiovascular System-high blood pressure, low blood pressure, high cholesterol, chest pain	◯	◯	◯
Integumentary System-skin cancer, psoriasis, eczema, acne, hair loss, rash	◯	◯	◯
Genitourinary System-kidney stones, infertility, bedwetting, prostate issues, PMS symptoms	◯	◯	◯
Constitutional System-fainting, low libido, poor appetite, fatigue, sudden weight, weakness	◯	◯	◯
Lymphatic System-swelling or pain in lymph nodes of neck, axillae, groin & other areas	◯	◯	◯

10. **Are you Pregnant?** Y / N Estimated Due Date: ______________ Any complications? ______________________________

11. **Prior illnesses, operations, injuries or treatments:** ____

12. **Allergies** (drugs, chemicals, foods, etc.) ____

13. **Medications/Supplements:** ____

14. **Social History** (Tell us about your health habits):____

15. **Occupational Stress** (Chemical, physical, psychological):____

Tobacco Use: Y / N Per:_____________ Caffeine: Y / N Per:_____________ Alcohol: Y / N Per:________________

General

Check all that apply, and for each note if it is current or past.

- ◯ Night Sweats
- ◯ Recurrent Infections
- ◯ Strong thirst (prefer hot or cold?)
- ◯ Fatigue
- ◯ Sweat easily
- ◯ Bleed or bruise easily
- ◯ Thirst with no desire to drink?
- ◯ Poor Sleep
- ◯ Overweight
- ◯ Poor Balance
- ◯ Tremors
- ◯ Edema
- ◯ Underweight
- ◯ Sudden energy drops? Time of day: ____

Head/Eyes/Ears/Nose/Throat

- ◯ Sore eyes
- ◯ Eye Pain
- ◯ Blurry vision
- ◯ Squint
- ◯ Glasses
- ◯ Color blindness
- ◯ Night blindness
- ◯ Excessive Tearing
- ◯ Spots in front of eyes
- ◯ Dizziness
- ◯ Blocked nose
- ◯ Nose bleeds
- ◯ Snoring
- ◯ Discharge from ear
- ◯ Ringing in ears
- ◯ Poor hearing
- ◯ Sores on lips/mouth
- ◯ Hoarseness
- ◯ Tonsillitis
- ◯ Teeth problems
- ◯ Grinding teeth
- ◯ Swollen glands
- ◯ Nasal discharge
- ◯ Recurrent sore throat
- ◯ Facial Pain
- ◯ Migraines
- ◯ Headaches Where _______________________ When_______________________
- ◯ Other ____

Skin

- ◯ Rashes
- ◯ Itching
- ◯ Eczema
- ◯ Oozing
- ◯ Pimples
- ◯ Dry skin / scalp
- ◯ Recent moles
- ◯ Changes in hair/skin
- ◯ Other: ____

Genital-urinary

- ◯ Pain on urination
- ◯ Urgency with urination
- ◯ Frequent urination
- ◯ Blood in urine
- ◯ Prostate problems
- ◯ Decrease in urinary
- ◯ Unable to hold urine
- ◯ Incontinence at night
- ◯ Dribbling urination
- ◯ Kidney stones
- ◯ Changes in sexual drive
- ◯ Rashes
- ◯ Impotency
- ◯ Other _________________________________
- ◯ Do you wake at night to urinate? How many times? _________

Respiratory

- ◯ Difficulty breathing
- ◯ Pain with breathing
- ◯ Shallow breathing
- ◯ Shortness of breath
- ◯ Bronchitis
- ◯ Pneumonia
- ◯ Asthma/Wheezing
- ◯ Status asthmaticus
- ◯ Recurrent cough
- ◯ Production of phlegm
- ◯ Other ____

Cardiovascular

- ◯ Pacemaker
- ◯ High Blood Pressure
- ◯ Low Blood Pressure
- ◯ Chest discomfort/pain
- ◯ Heart Palpitations
- ◯ Cold hands or feet
- ◯ Swelling of hands or feet
- ◯ Blood Clots
- ◯ Spider veins
- ◯ Fainting
- ◯ Other ____

Musculoskeletal

○ Neck ache/pain ○ Back ache/pain ○ Knee ache/pain ○ Shoulder pain ○ Elbow/Forearm pain

○ Hand/Wrist pain ○ Foot/Ankle pain ○ Torn tissues ○ Muscle pain/weakness ○ Hernia

○ Prostheses ○ Other ____________________

Neurological

○ Seizures ○ Nerve damage ○ Paralysis ○ Difficulty in concentrating ○ Sleep disorder ○ Stroke

○ Concussion ○ Loss of balance ○ Vertigo ○ Lack of coordination ○ Poor memory ○ Other__________

Gynecological

Are you pregnant now? ○ Yes, Due Date: ___________ ○ No # Of Pregnancies______ # births_____ # premature births________

Do you practice birth control? ○ Yes ○ No What type and for how long? ______________________

Age of 1st menses_______# days between menses_______ Duration of menses________1st day of last menses________

Age of menopause________________ Date of last PAP____________________

○ PMS ○ Irregular periods ○ Painful periods ○ Light periods ○ Heavy periods

○ Fibroids ○ Endometriosis ○ Infertility ○ Breast lumps ○ Vaginal discharge

○ Vaginal sores ○ Nipple discharge ○ Postcoital bleeding ○ Clots ○ Other __________________

Digestion

○ Bad breath ○ Change in appetite ○ Loose stools / Diarrhea ○ Heartburn ○ Indigestion

○ Weight gain ○ Weight loss ○ Bloody stools ○ Belching ○ Nausea

○ Black stools ○ Hemorrhoids ○ Rectal pain ○ Gas ○ Vomiting

○ Green stool ○ Strong smelling stools ○ Pain with passing stools ○ Constipation (not daily, or difficult)

○ Bulimia ○ Anorexia nervosa ○ Abdominal pain/cramps ○ Other ______________________________

Behavioral

○ Vacant ○ Easily susceptible to stress ○ Panic Attacks ○ Depression ○ Fear

○ Moody ○ Aggressive/Bad temper ○ Lose control of emotions ○ Substance abuse ○ Anxiety

○ Other ____________________

Have you ever been treated for emotional problems? ○ Yes ○ No

Comments:

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Thank you for taking the time to fill out this form thoroughly. It will help us serve you better. If we believe that we cannot assist you with your health care needs, we will be more than happy to refer you to the appropriate health care professional. If you have any questions, please ask. Thank you.

Patient/Guardian Signature: ____Date: ________________

If the patient is a minor child, print child's full name: ____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

____ ____________________________

Patient/Guardian Signature Date (MM/DD/YYYY)

If the patient is a minor child, print child's full name: ____