BluegrassChiropractic | REGISTRATION & HISTORY

Patient Information

Last Name ______________________ First Name _______________

SS # ____

Address ____

E-mail ____

City __________________________ State________ Zip___________

Sex: ❏ Male ❏ Female

Birthdate __________________ /____________ /_______________

Height______________________ Weight____________________

Home Phone ___________________ Cell Phone_________________

❏ Married ❏ Widowed ❏ Single ❏ Minor ❏ Separated

❏ Divorced ❏ Partnered

Employer / School ____

If Employed, Occupation ___________________________________

Spouse Name ____

Spouse Birthdate _____________ /____________ /______________

Spouse SS# ______________ — _______________— _______________

Whom may we thank for referring you? _________________________

Home Phone ___________________ Cell Phone_________________

Best Time / Number to reach you _____________________________

IN CASE OF EMERGENCY, CONTACT:

Name_________________________ Relationship _________________

Home Phone__________________ Work Phone__________________

Patient Condition

Reason for Visit____

When did your symptoms appear?__________________________________

Is this condition getting progressively worse? ❏ YES ❏ NO ❏ UNKNOWN

Mark an X on the picture below where you continue to have pain, numbness, or tingling. Then circle the number which best indicates the severity of your pain on a scale from 1 (least) to 10 (severe):

1 2 3 4 5 6 7 8 9 10

How often do you have this pain? ______________________________

Is it constant or does it come and go? _________________________

Does it interfere with your: ❏ Work ❏ Sleep ❏ Daily Routine

❏ Recreation

Check activities or movements that are painful to perform:

❏ Sitting ❏ Standing ❏ Walking ❏ Bending ❏ Lying Down

❏ Turning

Type of Pain:

______ Sharp

______ Dull

______ Throbbing

______ Numbness

______ Aching

______ Burning

______ Shooting

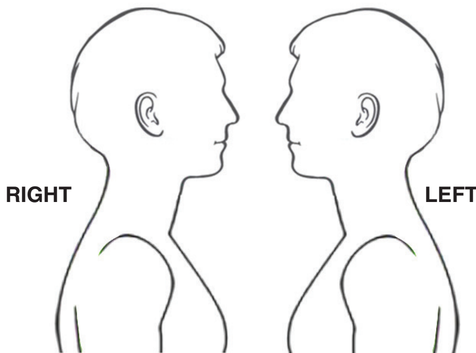
______ Tingling

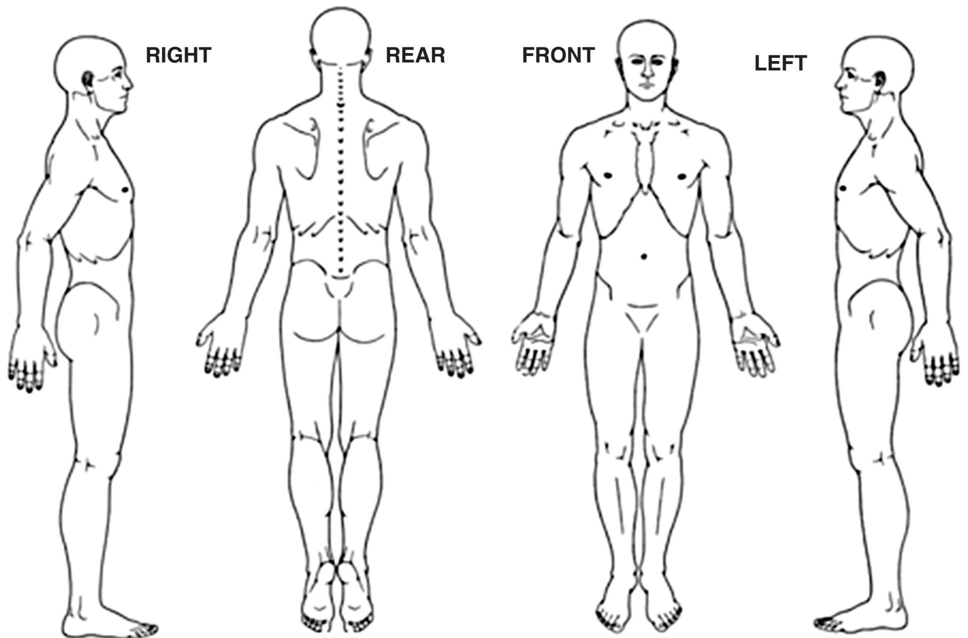
______ Cramps

______ Stiffness

______ Swelling

______ Other





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Patient Condition (continue if applicable)

What is your SECOND complaint? ______________________ Date problem began ______________

How did this problem begin? (falling, lifting, etc.) ______________________

is your condition changing? ❑ GETTING BETTER ❑ GETTING WORSE ❑ NO CHANGE Have you had this condition in the past? ❑ YES ❑ NO

How often do you experience your symptoms? ❑ Constantly (76-100% of the ay) ❑ Frequently (51-75% of the day)
❑ Occasionally (26-50% of the day) ❑ Intermittently (0-25% of the day)

Describe the nature of your symptoms: ❑ SHARP ❑ DULL ❑ NUMB ❑ BURNING ❑ SHOOTING ❑ TINGLING ❑ TIGHTNESS
❑ RADIATING PAIN ❑ STABBING ❑ THROBBING ❑ OTHER: ______________________

Please rate your pain on a scale of 1 - 10 (0 = NO PAIN & 10 = EXCRUCIATING): 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition? (working, exercise, etc) ______________________

What makes your pain better? (ice, heat, massage, etc) ______________________

Health Information

Place mark on YES or NO to indicate if you have had any of the following:

Condition			Condition			Condition			Condition		
AIDS/HIV	❑ Yes	❑ No	Chicken Pox	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Rheumatoid Arthritis	❑ Yes	❑ No
Alcoholism	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Measles	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Allergy Shots	❑ Yes	❑ No	Emphysema	❑ Yes	❑ No	Migraine Headaches	❑ Yes	❑ No	Scarlet Fever	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Epilepsy	❑ Yes	❑ No	Miscarriage	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Anorexia	❑ Yes	❑ No	Fractures	❑ Yes	❑ No	Mononucleosis	❑ Yes	❑ No	Suicide Attempt	❑ Yes	❑ No
Appendicitis	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Multiple Sclerosis	❑ Yes	❑ No	Thyroid Problems	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Goiter	❑ Yes	❑ No	Mumps	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Gonorrhea	❑ Yes	❑ No	Osteoporosis	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
BleedIng Disorder	❑ Yes	❑ No	Gout	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No	Tumors, Growths	❑ Yes	❑ No
Breast Lump	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No	Parkinson's Disease	❑ Yes	❑ No	Typhoid Fever	❑ Yes	❑ No
Bronchitis	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No	Pinched Nerve	❑ Yes	❑ No	Ulcers	❑ Yes	❑ No
Bulimia	❑ Yes	❑ No	Hernia	❑ Yes	❑ No	Pneumonia	❑ Yes	❑ No	Vaginal Disorders	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Herniated Disk	❑ Yes	❑ No	Polio	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Prostate Problem	❑ Yes	❑ No	Whooping Cough	❑ Yes	❑ No
Chemical	❑ Yes	❑ No	High Cholesterol	❑ Yes	❑ No	Prosthesis	❑ Yes	❑ No	Other______________		
			Kidney Disease	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No	______________		

Medications (please list all you are currently taking)

Product	**Dosage**	**(Mg) milligrams**
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

______________________________ ______________

Patient Guardian Signature Date