BluegrassChiropractic | REGISTRATION & HISTORY

Patient Information

SS # _____

Last Name _____ First Name _____

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 _____

Work Address _____

Work Phone _____

Spouse Name _____

Spouse Birthdate _____ /_____ /_____

Spouse SS# _____ — _____ — _____

Spouse Employer_____

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_____

Check Any Allergies

❑ Animal ❑ Aspirin ❑ Bees ❑ Chocolate ❑ Dairy
❑ Dust ❑ Eggs ❑ Latex ❑ Molds ❑ Penicillin
❑ Rubber ❑ Rubber ❑ Shellfish ❑ Soaps ❑ Wheat
❑ Ragweed / Pollen ❑ Seasonal Allergies ❑ X-Ray Dye
❑ Other

List All Surgeries

❑ Back Date_____
❑ Brain Date_____
❑ Shoulder Date_____
❑ Neck Date_____
❑ Knee Date_____
❑ Hip Date_____
❑ Wrist Date_____
❑ Other Date_____

Accident Information / Worker's Comp

Is condition due to an accident? ❑ YES ❑ NO Date_____

Type of accident: ❑ AUTO ❑ WORK ❑ HOME ❑ OTHER
To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Worker's Comp ❑ Other

Attorney Name (if applicable)_____

Patient Condition

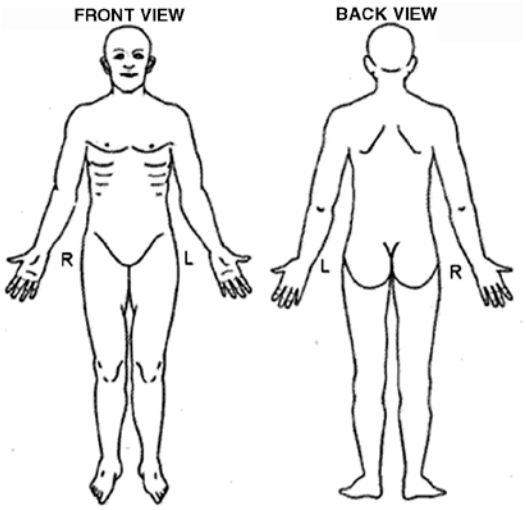
Reason for Visit_____

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 (sever):

1 2 3 4 5 6 7 8 9 10



Type of Pain:

_____ Sharp
_____ Dull
_____ Throbbing
_____ Numbness
_____ Aching
_____ Burning
_____ Shooting
_____ Tingling
_____ Cramps
_____ Stiffness
_____ Swelling
_____ Other

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

Family History: Mother, Father, Grandparents, Sister, or Brother

❑ Arthritis Who_____
❑ Asthma Who_____
❑ Back Problem Who_____
❑ Cancer Who_____
❑ High Blood Pres. Who_____
❑ Diabetes Who_____
❑ Heart Attack Who_____
❑ Stroke Who_____
❑ Depression Who_____

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Health Information

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

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
Bleedlng 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	_____		

Place mark on all which apply:

Exercise
- ❑ None
- ❑ Moderate
- ❑ Daily
- ❑ Heavy

Work Activity
- ❑ Sitting
- ❑ Standing
- ❑ Light Labor
- ❑ Heavy Labor

Habits
- ❑ Smoking — Packs/Day_____
- ❑ Alcohol — Drinks/ Week _____
- ❑ Coffee/Caffeine Drinks — Cups/Day_____
- ❑ High Stress Level — Reason _____

Are you pregnant? ❑ YES ❑ NO Due Date _____

Medications: please list all you are currently taking

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

Pharmacy Name_____ Pharmacy Phone Number _____