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

As a Courtesy, 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.

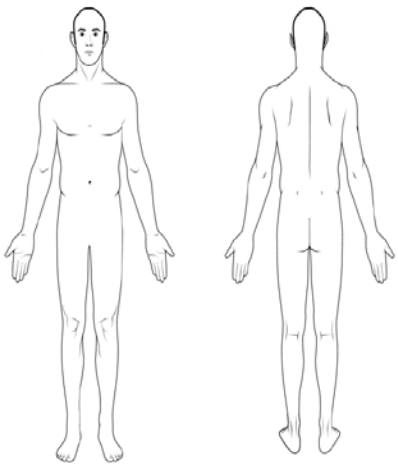
Emergency Contact | Relationship & Phone

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

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? _____

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:_____

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: _____

Modified: 08/07/2017