

# Chiropractic Registration and History

**Today's Date:** \_\_\_\_\_

**Please Print Clearly**

**Patient Information**

Name: \_\_\_\_\_  
 Street: \_\_\_\_\_  
 City/St./Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 Email \_\_\_\_\_  
 Gender \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  
 Marital Status \_\_\_\_\_  
 Contact Method: CELL HOME EMAIL  
 Pref Language: \_\_\_\_\_  
 Employer Name and City: \_\_\_\_\_  
 \_\_\_\_\_  
 Who referred you to our office? \_\_\_\_\_

**Office Use:**

\_\_\_\_\_

**Race/Ethnicity:**

\_\_\_\_\_

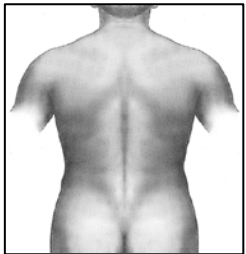
**Smoke?** (circle one)  
 Everyday Occas Never Former

**Chiropractic History**

Chiropractor's Name \_\_\_\_\_  
 Reason \_\_\_\_\_  
 Date of Last Visit \_\_\_\_\_

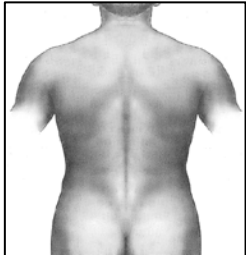
**Primary Complaints**

**Mark Location of #1 Complaint**



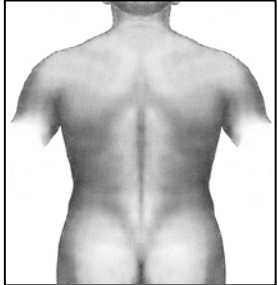
Date the pain started - \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Pain Rating at it's worst = 1(least) to 10(worst) - \_\_\_\_\_  
 Type of Pain (circle all that apply)  
 SHARP DULL THROBBING INTERMITTENT CONSTANT  
 BURNING STIFFNESS SHOOTING ACHING NUMBNESS/TINGLING  
 Does it interfere with any Acts of Daily Living?  
 SITTING STANDING WORK SLEEP  
 LYING DOWN WALKING BENDING ROUTINE

**Mark Location of #2 Complaint**



Date the pain started - \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Pain Rating at it's worst = 1(least) to 10(worst) - \_\_\_\_\_  
 Type of Pain (circle all that apply)  
 SHARP DULL THROBBING INTERMITTENT CONSTANT  
 BURNING STIFFNESS SHOOTING ACHING NUMBNESS/TINGLING  
 Does it interfere with any Acts of Daily Living?  
 SITTING STANDING WORK SLEEP  
 LYING DOWN WALKING BENDING ROUTINE

**Mark Location of #3 Complaint**



Date the pain started - \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Pain Rating at it's worst = 1(least) to 10(worst) - \_\_\_\_\_  
 Baseline Pain Rating = 1(least) to 10(worst) - \_\_\_\_\_  
 Type of Pain (circle all that apply)  
 SHARP DULL THROBBING INTERMITTENT CONSTANT  
 BURNING STIFFNESS SHOOTING ACHING NUMBNESS/TINGLING  
 Does it interfere with any Acts of Daily Living?  
 SITTING STANDING WORK SLEEP  
 LYING DOWN WALKING BENDING ROUTINE

**List all at Home Remedies:** \_\_\_\_\_

\_\_\_\_\_

**Your Personal Health History (please check all that apply)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Constipation          | <input type="checkbox"/> Allergies _____          | <input type="checkbox"/> Nervousness                 |
| <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Parkinsons                  |
| <input type="checkbox"/> Loss of Bowel Control | <input type="checkbox"/> Fibromyalgia             | <input type="checkbox"/> Pinched Nerve               |
| <input type="checkbox"/> Ulcers                | <input type="checkbox"/> German Measles           | <input type="checkbox"/> Psychological Disorder      |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Dementia/ Alzheimers        |
| <input type="checkbox"/> Broken Bones          | <input type="checkbox"/> Lung Disease             | <input type="checkbox"/> Menstrual Cramps            |
| <input type="checkbox"/> Dislocated Joints     | <input type="checkbox"/> Polio                    | <input type="checkbox"/> Reproductive Disorders      |
| <input type="checkbox"/> Herniated [ Disc      | <input type="checkbox"/> Rheumatic Fever          | <input type="checkbox"/> AIDS/HIV                    |
| <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Scarlet Fever            | <input type="checkbox"/> Anemia                      |
| <input type="checkbox"/> Rheumatoid Arthritis  | <input type="checkbox"/> Sinus Trouble            | <input type="checkbox"/> Bladder Trouble             |
| <input type="checkbox"/> Scoliosis             | <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Epilepsy/Seizures           |
| <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Venereal Disease         | <input type="checkbox"/> Endocrine/Hormonal Problems |
| <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Cancer _____             | <input type="checkbox"/> Rheumatism                  |
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Tumors of Growths        | <input type="checkbox"/> Diabetes                    |
| <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Concussion               | <input type="checkbox"/> Other:                      |
| <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Depression _____         |  |
| <input type="checkbox"/> Poor Circulation      | <input type="checkbox"/> Migraines/Headaches      | <input type="checkbox"/> Other:                      |
| <input type="checkbox"/> Stroke                | <input type="checkbox"/> Multiple Sclerosis _____ |  |
| <input type="checkbox"/> Clotting Disorder     | <input type="checkbox"/> Muscular Dystrophy       | <input type="checkbox"/> Other: _____                |

**Exercise**

- NONE
- MODERATE
- HEAVY

**Work Activity**

- SITTING
- STANDING
- HEAVY LABOR

**Habits**

- SMOKING - PACKS/DAY \_\_\_\_\_
- DRINKING - DRINKS/WEEK \_\_\_\_\_

**Accidents/Injuries (please list with dates)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Surgeries (please list with dates)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**List All Medications you are currently taking**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies (medications, etc.)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Family History**

( List Mother, Father, Sister, Brother, Children only)

	Illness	Type	Family Member
<input type="checkbox"/>	Cancer		
<input type="checkbox"/>	Clotting Disorder		
<input type="checkbox"/>	Dementia/Alzheimers		
<input type="checkbox"/>	Diabetes		
<input type="checkbox"/>	Gastrointestinal Disorder		
<input type="checkbox"/>	Heart Disease		
<input type="checkbox"/>	High Blood Pressure		
<input type="checkbox"/>	Kidney Disease		
<input type="checkbox"/>	Lung Disease		
<input type="checkbox"/>	Osteoporosis		
<input type="checkbox"/>	Psychological Disorder		
<input type="checkbox"/>	Septicemia		
<input type="checkbox"/>	Stroke		
<input type="checkbox"/>	Sudden Infant Death		
<input type="checkbox"/>	Other		

# Doctor-Patient Relationship in Chiropractic/Privacy Statement

**I understand that OnSite Chiropractic is an optional benefit and is not mandatory.  
I do not hold my employer responsible for the results of this program.**

The purpose of Chiropractic is to restore and maintain the integrity of the spinal cord and its' nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine (called vertebra). Misalignments of the vertebra, which interfere with the functions of these pathways, are called **SUBLUXATIONS**. Subluxations come from many causes and prevent various organs, glands and tissues from functioning properly.

By means of a Chiropractic **ADJUSTMENT**, subluxations are corrected (reduced). Thus, the normal nerve function restores itself. The goal of Chiropractic is to adjust vertebral subluxations for the purpose of allowing the proper transmission of nerve supply over nerve pathways to every part of the body at all times.

This allows the body's inborn, innate healing ability to work to maximum efficiency. With a proper nerve supply, health improves. In some, symptoms clear up quickly. In others, the process is slower, and in some, it is only partial or not at all. Regardless of what the disease is called, the Chiropractor does not offer to heal or treat it. The Chiropractor's only goal is to allow the body to heal itself and his only means is the correction of the vertebral subluxation.

Please understand that Chiropractic is **NOT** a substitute for medical treatments of any kind. Also, **NO** statement of the chiropractor is intended as a medical diagnosis and should not be confused as such. Chiropractic is not intended to be a treatment of the symptoms of a medical condition or to treat the causes of a medical condition.

Only a chiropractor can determine if your case is a chiropractic case. Medical doctors diagnose disease and chiropractors diagnose vertebral subluxations. Your diagnosis in this clinic will reflect spinal nerve interference, which is caused by vertebral subluxations. Our doctors will work with any other health care provider for your benefit. Inversely, you should expect all other health care providers to work together with your chiropractor for your benefit. This team approach to your health care will benefit you the patient the best.

The patient, in coming to the chiropractor, gives the chiropractor permission and authority to adjust the patient for spinal subluxations. If the patient is aware of any latent pathological defects, illness or deformities, which would not otherwise come to the attention of the chiropractor, it is their responsibility to notify the chiropractor. The chiropractor, of course, will not provide chiropractic adjustments if he is aware of any such conditions. The chiropractor provides a specialized health service in the detection and correction of the vertebral subluxation and its related components. Any risks regarding chiropractic treatment will be explained, in detail, upon request.

The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the **Health Insurance Portability and Accountability Act** of 1996 ("HIPAA"). A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

You can be assured that our clinic takes your privacy seriously and is in compliance with all HIPPA guidelines. Your health information will not be disclosed without your permission or will your name, address or telephone number be disclosed to any third party. Our privacy policy is available at the front desk upon your request.

Just as in any good relationship, proper communication is an absolute necessity. We want to help you attain your goal of health. If at any time your response is not satisfactory, we will gladly assist you in choosing a referral doctor for another opinion. Your health is our number one priority.

I, \_\_\_\_\_, have read the above, understand it fully and undertake Chiropractic care on this basis.  
(Please Print Name)

Signature \_\_\_\_\_ Date \_\_\_\_\_

**If you have any questions or concerns about your care at this location, please call (844) 307-9786**

**OnSite Chiropractic**