



## NEW PATIENT REGISTRATION

All questions contained in this questionnaire are strictly confidential  
And will become part of your medical record

(Please Print)

Physician:			Chiropractor:		
PATIENT INFORMATION					
Patient's Last Name:		First:	M.I.:	Marital Status (Check one) :	
				<input type="checkbox"/> Single	<input type="checkbox"/> Divorced
				<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
Date of Birth (MM/DD/YYYY):		Sex:	Age:	Social Security:	Primary Phone :
/ /		<input type="checkbox"/> M <input type="checkbox"/> F			( )
Email:			Spouse's Last Name:		First: M.I.:
Street Address or PO Box:					Apt # :
City:			State:	Zip Code:	
Occupation:		Employer:		Employer Phone:	
				( )	

Referred to Clinic by (Check all that apply):					
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Physician:		<input type="checkbox"/> Drive-By	<input type="checkbox"/> Internet
<input type="checkbox"/> Newspaper	<input type="checkbox"/> Provider Directory	<input type="checkbox"/> TV	<input type="checkbox"/> Web Page	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other:

PRIMARY CONTACT INFORMATION			
Primary Contact (if different than above):		Relationship to patient:	Home Phone:
			( )
Home Address:		Apt #:	Cell Phone:
			( )
City:		State:	Zip Code:
Occupation:		Employer:	Employer Phone:
			( )

<b>ORIGINAL DATE:</b>	<b>DATES REVISED:</b>
	(For Staff Use Only)



## MEDICAL HISTORY

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(Please Print)

Patient's Name:		Today's Date:	
<b>REASON FOR VISIT</b>			
<b>Current complaints</b> (Check all that apply)			
<input type="checkbox"/> Achilles Tendon Pain	<input type="checkbox"/> Diabetic Feet	<input type="checkbox"/> Ingrown Toe Nails	
<input type="checkbox"/> Ankle Pain	<input type="checkbox"/> Flat Feet or High Arches	<input type="checkbox"/> Knee Pain or Discomfort	
<input type="checkbox"/> Athlete's Foot	<input type="checkbox"/> Foot or Leg Cramps	<input type="checkbox"/> Lower Back Pain	
<input type="checkbox"/> Ball of Foot Pain	<input type="checkbox"/> Fungal Toenails	<input type="checkbox"/> Plantar Warts	
<input type="checkbox"/> Bunions	<input type="checkbox"/> Hammer Toes	<input type="checkbox"/> Swelling in Ankles and /or Feet	
<input type="checkbox"/> Corns and Calluses	<input type="checkbox"/> Heel Pain	<input type="checkbox"/> Walking Instability	
<input type="checkbox"/> Numbness in Feet and/or Legs	<input type="checkbox"/> Hip Pain or Discomfort	<input type="checkbox"/> Other:	
<b>Brief Explanation:</b>			
<b>Previous treatments tried</b> (Check all that apply)			
<input type="checkbox"/> Arch Supports / Orthotics	<input type="checkbox"/> Heat Application	<input type="checkbox"/> Shoes	
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Home Remedies	<input type="checkbox"/> Soaking	
<input type="checkbox"/> Ice Application	<input type="checkbox"/> Pain Pills	<input type="checkbox"/> Surgery	
<input type="checkbox"/> Injections (ex. Cortisone)	<input type="checkbox"/> Rest	<input type="checkbox"/> Other:	
Would you prefer a drug-free treatment plan, if possible?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like to walk better or with less pain?		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Applicable

## PERSONAL HEALTH HISTORY

### General Information

Height: _____ feet _____ inches	Weight: _____ lbs.	Shoe Size: M W _____	Do have young children? <input type="checkbox"/> Yes <input type="checkbox"/> No
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### Drug or Medication Allergies

 (Check all that apply)

<input type="checkbox"/> <b>No Allergies</b>	<input type="checkbox"/> Cortisone	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Iodine	<input type="checkbox"/> Others :
<input type="checkbox"/> Codeine	<input type="checkbox"/> Novocain	

Type of reaction (ex. rash, nausea, breathing trouble, etc.):

**Please fill out both sides of this form**

**Medications** (Please list all prescribed and over-the-counter drugs or provide a list for copying)

Name of Medication	Dosage or Strength	Frequency	Name of Medication	Dosage or Strength	Frequency

**Previous Surgeries** (Please list all previous surgeries and year if known)

Procedure	Year	Procedure	Year

**Past Medical Conditions** (Check all that apply)

<input type="checkbox"/> Acid Reflux Disease (Heartburn)	<input type="checkbox"/> Cancer, type:	<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Joint Implants	<input type="checkbox"/> Stomach Ulcer(s)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Bleeding / Clotting Disorders	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Walking Trouble
<input type="checkbox"/> Others:			

**Family Health History** (Check all that apply and list what relative) (ex.  Flat Feet – Dad)

<input type="checkbox"/> Arthritis -	<input type="checkbox"/> Diabetes -	<input type="checkbox"/> Heart Problems -
<input type="checkbox"/> Bunions -	<input type="checkbox"/> Flat Feet -	<input type="checkbox"/> Ingrown Nails -
<input type="checkbox"/> Cancer, type:	<input type="checkbox"/> Hammer Toes -	<input type="checkbox"/> Other:

**HEALTH HABITS AND PERSONAL SAFETY**

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)					
	<input type="checkbox"/> Mild exercise (ex. Climb stairs, walk 3 blocks, golf)					
	<input type="checkbox"/> Occasional vigorous exercise (ex. Work or recreation less than 4x / week for 30 minutes)					
	<input type="checkbox"/> Regular vigorous exercise (ex. Work or recreation 4x or more / week for 30 minutes)					
	What specific sports or activities do you participate?					
<b>Alcohol</b>	How often do you drink alcohol?	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely (Special Occasions)	<input type="checkbox"/> Occasionally (With Friends)	<input type="checkbox"/> Periodically (1-2 times a week)	<input type="checkbox"/> Frequently (3+ times a week)
	<b>Tobacco</b>	Do you use tobacco products?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Chew	<input type="checkbox"/> Smoke
How many years have you used these products?		<input type="checkbox"/> 0 to 10 years	<input type="checkbox"/> 10 to 20 years	<input type="checkbox"/> 20+ years	Quit Date:	
<b>Personal Safety</b>	Is there someone at home who can help you if you are ill or recovering from surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
	If "No" – Is there someone who can come help you if you are ill or recovering from surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

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