ACTIVE LIFE CHIROPRACTIC
a Sports Injury & Family Practice

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www.Active-Life-Chiropractic.com

Registration and Health History

Name: _____ **Today's Date:** _____
First Middle Last

Address: _____
Street Apt# City State Zip

Cell phone: (____) _____ **Home phone: (____)** _____ **Email:** _____

Date of Birth: _____ **Gender:** _____ **Marital Status:** _____ **SS #:** _____

Employer/Occupation: _____ **Phone: (____)** _____

Employer Address: _____
Street City State Zip

Emergency Contact/Relationship: _____ **Phone: (____)** _____

Body region 1 (Most painful/problematic)

Please indicate in which region of the body you are having symptoms _____

Note any symptoms other than pain you notice in this region_____

Is there any pain radiating from this area and/or any numbness, tingling or weakness _____

On a 0-10 scale with 0 being no pain at all and 10 being the worse imaginable pain please rate the following for this area: Average pain intensity_____/10 Current pain intensity ___/10 Worst pain intensity ___/10

How often do you feel these symptoms _____ How long do these symptoms last with each episode: _____ What % of time you are having pain in this region_____%

If pain is intermittent, explain when and/or what brings it on? _____

When did this initially start _____ Was it gradual or sudden _____ How did it happen _____

Nature of Injury ___**Auto** ___**Work** ____**Accident** ___**Illness** ___**Pain Management** ___**Other**

Have you had this before _____ Any imaging of this area/from when _____
When/Was it treated/By whom/Was it helpful _____

Any treatment for this occurrence _____

Body region 2

Please indicate in which region of the body you are having symptoms (Mark with N/A if none) _____

Note any symptoms other than pain you notice in this region_____

Is there any pain radiating from this area and/or any numbness, tingling or weakness _____

On a 0-10 scale with 0 being no pain at all and 10 being the worse imaginable pain please rate the following for this area: Average pain intensity_____/10 Current pain intensity ___/10 Worst pain intensity ___/10

How often do you feel these symptoms _____ How long do these symptoms last with each episode: _____ What % of time you are having pain in this region_____%

If pain is intermittent, explain when and/or what brings it on? _____

When did this initially start _____ Was it gradual or sudden _____ How did it happen _____

Nature of Injury ___**Auto** ___**Work** ____**Accident** ___**Illness** ___**Pain Management** ___**Other**

Have you had this before _____ Any imaging of this area/from when _____
When/Was it treated/By whom/Was it helpful _____

Any treatment for this occurrence _____

Body region 3

Please indicate in which region of the body you are having symptoms (Mark with N/A if none) _____

Note any symptoms other than pain you notice in this region_____

Is there any pain radiating from this area and/or any numbness, tingling or weakness _____

On a 0-10 scale with 0 being no pain at all and 10 being the worse imaginable pain please rate the following for this area: Average pain intensity_____/10 Current pain intensity ___/10 Worst pain intensity ___/10

How often do you feel these symptoms _____ How long do these symptoms last with each episode: _____ What % of time you are having pain in this region_____%

If pain is intermittent, explain when and/or what brings it on? _____

When did this initially start _____ Was it gradual or sudden _____ How did it happen _____

Nature of Injury ___**Auto** ___**Work** ____**Accident** ___**Illness** ___**Pain Management** ___**Other**

Have you had this before _____ Any imaging of this area/from when _____
When/Was it treated/By whom/Was it helpful _____

Any treatment for this occurrence _____

List up to 6 of your normal activities that your symptoms make difficult for you to complete. <u>Rate your ability to perform these on a 0-10 scale with 10 being completely able to perform and 0 being completely unable to perform.</u>

1)_____ Rating_____/10 2)_____ Rating_____/10

3)_____ Rating_____/10 4)_____ Rating_____/10

5)_____ Rating_____/10 6)_____ Rating_____/10

Patient Name _____ DOB _____

Have you seen a chiropractor before? ____ If yes, Whom/How did they adjust you/Were they effective/What do you wish they would have done differently _____

Anything else you feel might be related to these issues or anything more you would like to add? _____
_____

Any **weight change** not initiated by you over the past couple of months ____ How much _____
Night pain that wakes you from sleeping _____ **History of cancer** and When? _____
Any **bowel or bladder** changes recently/Explain _____

What are your **treatment goals** for this injury _____
Do you have any life events you are working toward _____

Any **major illnesses or hospitalizations or surgeries** _____
Any **general traumas** such as car accidents or sporting accidents _____
Have you ever been **knocked unconscious** ____ When _____
Any Hardware/Replacements? _____ **Where** _____

Did last physical include a PAP/Breast exam or Prostate check: Y/N **When**: _____ **Any Concerns/Positives**? ___
_____

Medications/Supplements/Vitamins (including over-the-counter)_____
_____

Family History of any health condition present or past (example: Cancer, heart disease, diabetes, arthritis, etc.) and when, and were they treated successfully? (Immediate family is most applicable here)
_____
_____

What is your **stress level** like from home _____ What is you **stress level** like from work _____
More emotional stressors or physical stressors? _____

How is your sleep _____ Any sleep aid use?_____
_____

FEMALES ONLY Previous pregnancies? ____ Number ____ Difficulty with labors? _____ 1st day of last menstrual period _____ If in menopause; was it natural or surgically induced _____ If Surgical-Why? _____ Are you on hormone therapy? ____
_____

Habits

Do you drink alcohol? _____ What do you drink and how often_____
Do you smoke or have you? When did you start _____ How many per day____ When did you quit _____
Any recreational drug use What type_____ When did you start_____ Times per day_____
Do you drink Coffee? Decaf or Regular? How many cups a day _____
Do you drink Soda? Diet or Regular? Kind_____ How many per day_____
Do you drink Water? How many glasses per day_____
Do you do any type of exercise? How often and for how long_____
How is your diet? _____
Any sugary foods? How often do you have sugary foods _____
Any artificial sweeteners? How often do you have these _____
How is your appetite? _____

Patient Name _____ DOB _____

Review of Systems Please mark the following for ongoing/current (C) or past (P)

GENERAL SYMPTOMS
__ Tremors
__ Twitching
__ Convulsions
__ Dizziness
__ Depression
__ Headache/Migraine
__ Nervousness
__ Numbness
__ Fatigue

MUSCLES & JOINTS
__ Low Back Problems
__ Joint Dislocation
__ Neck Problems
__ Arm/Hand Problems
__ Leg/Foot Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Degenerative Disc Disease
__ Disc Herniation
__ Walking Problems
__ Scoliosis
__ Broken Bones
__ Arthritis
__ Sciatica

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Chest Pain
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins
__ Fainting
__ Low Blood Pressure
__ Shortness of Breath
__ Pacemaker

NEUROLOGICAL
__ Anxiety
__ Mood Swings
__ Memory Loss
__ Phobia
__ Mental Disorder
__ Multiple Sclerosis
__ Epilepsy
__ Balance Issue
__ Cerebral Palsy

EAR/NOSE/THROAT
__ Ear Discharge/Drainage
__ Deafness
__ Earache
__ Ear Noises (ring/buzz)
__ Thyroid Dysfunction
__ Frequent Colds
__ Jaw Problems
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision/Blurred Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver Issue
__ Weight Loss/Gain
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Heartburn
__ Black Stool
__ Bloody Stool
__ Oily Stool
__ Blood in Urine
__ Hernia

SYSTEMIC
__ Chills
__ Fever
__ Night Sweats
__ Loss of Sleep
__ AIDS/HIV
__ Cancer
__ Tuberculosis
__ Hepatitis
__ Diabetes
__ Measles
__ Loss of Smell/Taste
__ Anemia

RESPIRATORY
__ Bronchitis
__ Emphysema
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm
__ Wheezing

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection/Stones
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder/Bowel Control
__ Venereal Disease

SKIN OR ALLERGIES
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____
__ Gout
__ Boils

FOR WOMEN ONLY
__ Birth Control -hormonal
__ Birth Control -physical
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Period
__ Vaginal Discharge
__ Breast Pain
__ Pregnant at this Time Y/N
__ Tubal Ligation
__ Lumps in Breast

SYSTEMIC CONTINUED
__ Mumps
__ Polio
__ Chicken Pox
__ Rheumatic Fever
__ Muscular Dystrophy
__ Pleurisy
__ Sensitive to Light/Sound
__ Alcoholism

Patient signature _____ DOB _____