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: (____)** __________

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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: **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 Dise
- __ 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/Draina
- __ Deafness
- __ Earache
- __ Ear Noises (ring/buzz)
- __ Thyroid Dysfunction
- __ Frequent Colds
- __ Jaw Problems
- __ Nasal Blockage
- __ Nose Bleeds
- __ Pain Behind Eyes
- __ Poor Vision/Blurred V
- __ 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 ____________