Petersen Chiropractic Center Registration & History Questionnaire

1. PATIENT INFORMATION – Please PRINT

Last Name _____ MI _____ First Name _____

Home Address _____ City _____ State _____ Zip _____

Age _____ Birth Date _____ Patient Social Security # (required for billing) _____

Gender ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

(if Married please complete the following) Spouse's Name _____ Spouse's Birth Date _____

Spouse's Social Security # _____ Spouse Employer _____

2. PATIENT PHONE NUMBERS

Patient Home Phone: _____ **In event of emergency, contact:**

Patient Cell Phone: _____ Name: _____ Relationship: _____

Patient Work Phone: _____ Home Phone: _____ Work Phone: _____

Patient E-mail Address: _____

E-mail addresses are used only for informational messages from this office. They are not given or sold to any other entity.

3. PATIENT EMPLOYER / SCHOOL INFORMATION

(Please check one) ☐ Employed ☐ Retired ☐ Student Employer/School: _____

Address: _____ City: _____ State _____ Zip _____

Phone: _____ Occupation: _____

4. REFERRAL INFORMATION

How did you hear about our office? (please check one of the following)

☐ Patient/Friend _____ ☐ Family Member _____ ☐ Dr. _____

☐ Insurance Directory ☐ Yellow Pages ☐ Newspaper Ad ☐ Sign/Drove By ☐ Other _____

5. ACCIDENT INFORMATION

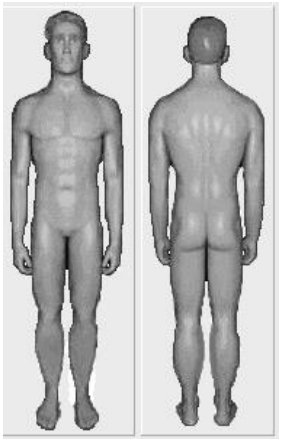
Is your current condition due to an accident? ☐ No ☐ Yes Date of Accident _____

Type of accident ☐ Auto accident ☐ Job Related accident ☐ Home Injury ☐ Other _____

To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Workers Comp ☐ Other

Attorney Name (if applicable) _____

6. PATIENT CONDITION



Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, tingling, or other symptoms

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Burning	☐ Tingling	☐ Cramps	☐ Stiffness
☐ Aching	☐ Swelling	☐ Shooting	☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Please complete page two on back

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7. HEALTH HISTORY

What Treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of Doctor(s) who have treated your condition _____

Date of Last:

Physical Exam		Spinal X-Ray		Blood Test	
Spinal Exam		Chest X-Ray		Urine Test	
Bone Mineral Density Test		MRI, CT-Scan			

Place a mark on "Yes" or "No" to indicate if you have had any of the following

AIDS/HIV	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herniated Disc	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Other	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No		
Chemical		High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/Day_____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day _____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason _____

Are you pregnant? ☐ No ☐ Yes Due Date _____

8. Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

9. MEDICATIONS	ALLERGIES	VITAMINS / HERBS / SUPPLEMENTS

- **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.**

Patient Signature _____ **Date** _____

☐ Adult Patient ☐ Parent or Guardian