LOY FAMILY Chiropractic

Registration and History

Patient Information

Date______________________________________
Patient Name_______________________________
Address____________________________________
____
City State Zip
Sex: M F Age___Birthdate________________
Single Married Widowed Separated
Divorced
Patient SS#________________________________
Occupation_________________________________
Employer___________________________________
Employer Address____________________________
Spouse's Name______________________________
Birthdate__________________________________
Occupation_________________________________
Spouse's Employer___________________________
Whom may we thank for referring you?
____

Phone Numbers and Email

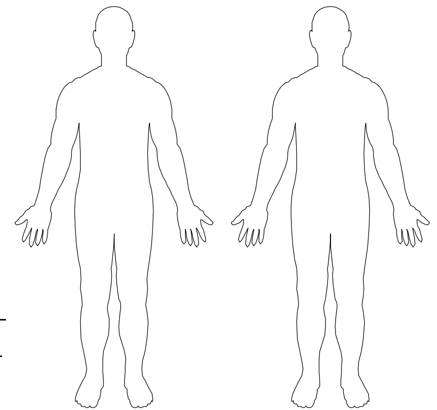
Home______________________________________
Work_____________________________Ext:_____
Cell_______________________________________
Email address_______________________________
Best time and place to reach you________________
IN CASE OF EMERGENCY, CONTACT:
Name___________________Relationship________
Home Phone_________________________________
Work Phone_______________________Ext:_____

Accident Information

Is condition due to an accident? yes No
Date of Accident_____________________________
Type of Accident Auto Work Home Other
To who have you made a report of your accident?
____

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 or tingling.
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)__
Type of pain: Sharp Dull Throbbing Numbness Ache Shooting
Burning Tingling Cramps Stiffness Swelling 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



Front **Back**

Health History

What Treatment have you already received for your condition? Medications Surgery Physical Therapy
Chiropractic Services None Other____
Name and address of other doctor(s) who have treated you for your condition________________________

Health History Continued:

Place a mark on "Yes" or "No" to indicate if you have had any of the following, Please Circle any that relate to your family history

AIDS/HIV	Yes	No	Gout	Yes	No	Liver Disease	Yes	No	Rheumatic Fever	Yes	No
Anemia	Yes	No	Heart Disease	Yes	No	Measles	Yes	No	Thyroid Problems	Yes	No
Arthritis	Yes	No	Hepatitis	Yes	No	Multiple Sclerosis	Yes	No	Tuberculosis	Yes	No
Bleeding Disorder	Yes	No	Herniated Disk	Yes	No	Mumps	Yes	No	Whooping Cough	Yes	No
Cancer	Yes	No	High Cholesterol	Yes	No	Osteoporosis	Yes	No			
Chicken Pox	Yes	No	Kidney Disease	Yes	No	Pneumonia	Yes	No			
Diabetes	Yes	No				Polio	Yes	No			
Eczema	Yes	No									
Epilepsy	Yes	No									

Please check any that apply in the last 6 months:

Abdominal Cramps
Allergies
Arm Pain
Black/Bloody Stool
Breast Lumps
Chest Pain
Cold/Tingling Extremities
Confusion/Depression
Constipation
Diarrhea
Difficulty Chewing
Discolored Urine
Dizziness
Ear Aches
Excessive Thirst
Excessive Urination
Fatigue
Fever
Gas/Bloating
General Stiffness
Headaches
Hearing Difficulty
Heart Problems
Heartburn
Hemorrhoids
Irregular Heartbeat
Joint Pain/Stiffness
Loss of Sleep
Low Back Pain
Menstrual Irregularity
Nausea
Neck Pain
Nervous
Numbness
Pain Between Shoulders
Paralysis
Poor/Excessive Appetite
Sexual Dysfunction
Shortness of Breath
Stress
Stroke
Varicose Veins
Vomiting

Females Only:

When was your last period?__________

Are you pregnant? Yes No Not Sure

Injuries/Surgeries you have had **Description** **Date**

- Falls ____________________
- Head Injuries ____________________
- Broken Bones ____________________
- Dislocations ____________________
- Surgeries ____________________
- Automobile Accidents ____________________

Medications **Allergies** **Vitamins/Herbs/Minerals**