CONFIDENTIAL

# New Patient Registration

**HIPAA**
Protected Health Information
Authorized Access Only

## PERSONAL INFORMATION

**Name** _____ **Social Security** _____

**Address** _____ **City** _____ **State** _____ **Zip** _____

**Telephone: Home:** _____ **Cell:** _____ **Marital Status: M S W D**

**Age** _____ **Date of Birth** _____ **# Children** _____ **Occupation** _____

**Referred by** _____ **Emergency Contact** _____ **Phone** _____

## HEALTH INFORMATION

**Have you ever been to a chiropractor before?** _____ **If so, how long ago?** _____

**What is you reason for your visit today ?** _____

**How long have you had this condition?** _____

**What makes your complaint worse?** _____

**What makes your complaint better?** _____

**Is this condition getting better, worse or staying the same?** _____

**Have you seen any other doctors for this complaint?** _____

**Any other complaints you would like the doctor to know?** _____

**List any surgical procedures and when** _____

**Currently, what prescription or OTC drugs are you taking?** _____

**What was the date of your last Physical with your PCP?** _____

**PLEASE, CHECK IF YOU HAVE EVER SUFFERED FROM ANY OF THE FOLLOWING:**

- ☐ Dizziness
- ☐ Digestive Disorders
- ☐ Low Back Pain
- ☐ Nervousness
- ☐ Neck Pain
- ☐ Heart Trouble
- ☐ Headaches
- ☐ High Cholesterol
- ☐ Sinus Trouble
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Neuritis
- ☐ Arthritis
- ☐ Asthma

**PLEASE, INDICATE WHERE YOU HAVE PAIN BY MARKING ON THE DIAGRAM**