



## PATIENT REGISTRATION FORM

Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Preferred Name \_\_\_\_\_

DOB \_\_\_\_\_

Email \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Marital Status:   \_\_\_ Single       \_\_\_ Married       \_\_\_ Separated       \_\_\_ Divorced       \_\_\_ Widowed

How did you hear about us?   \_\_\_ Doctor       \_\_\_ Friend       \_\_\_ Family Member       \_\_\_ Insurance Book       \_\_\_ Friend  
                                  \_\_\_ Website       \_\_\_ Social Media       \_\_\_ Other \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_

Phone \_\_\_\_\_

Employment Status:   \_\_\_ Full-Time   \_\_\_ Part-Time   \_\_\_ Self Employed   \_\_\_ None   \_\_\_ Disabled   \_\_\_ Student

Patient's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Subscriber:       Self       Spouse       Child



**Attorney's Name :** \_\_\_\_\_

• Attorney's Phone # \_\_\_\_\_

**Labor & Industries**

• Date of Injury: \_\_\_\_\_ Claim # \_\_\_\_\_

**Patient's Auto Insurance Name** \_\_\_\_\_

• Phone # \_\_\_\_\_ Claim # \_\_\_\_\_

Other Driver Information: Name \_\_\_\_\_

• Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

• Drivers Ins. Co. \_\_\_\_\_

• Ins Co. phone # \_\_\_\_\_

• Claim # \_\_\_\_\_

**Patient Signature**

**Date**



## Current Symptoms

Name \_\_\_\_\_

Date \_\_\_\_\_

Reason for today's visit is a result of:

\_\_\_\_ Work Accident      \_\_\_\_ Auto Accident      \_\_\_\_ Sport Accident

\_\_\_\_ Trauma      \_\_\_\_ Chronic      \_\_\_\_ Check Up

Have you ever been treated by a Chiropractor before? \_\_\_\_ Yes      \_\_\_\_ No

Major Concerns:

1. \_\_\_\_\_

How Intense? (0-Least; 10-Worst)      0    1    2    3    4    5    6    7    8    9    10

How Frequent? (Rarely - All the time)      25%    50%    75%    100%

Interfere with Work, Sleep, Daily Routine?      W    S    D

2. \_\_\_\_\_

How Intense? (0-Least; 10-Worst)      0    1    2    3    4    5    6    7    8    9    10

How Frequent? (Rarely - All the time)      25%    50%    75%    100%

Interfere with Work, Sleep, Daily Routine?      W    S    D

3. \_\_\_\_\_

How Intense? (0-Least; 10-Worst)      0    1    2    3    4    5    6    7    8    9    10

How Frequent? (Rarely - All the time)      25%    50%    75%    100%

Interfere with Work, Sleep, Daily Routine?      W    S    D

4. \_\_\_\_\_

How Intense? (0-Least; 10-Worst)      0    1    2    3    4    5    6    7    8    9    10

How Frequent? (Rarely - All the time)      25%    50%    75%    100%

Interfere with Work, Sleep, Daily Routine?      W    S    D



When did this first become a concern for you? \_\_\_\_\_

\_\_\_\_\_

Have you ever experienced these symptoms before? \_\_\_\_Yes \_\_\_\_No

If Yes, when? \_\_\_\_\_

Have you been treated for these past episodes(s)? \_\_\_\_Yes \_\_\_\_No

If Yes, by whom? Chiropractor MD Osteopath Physical Therapist  
Massage Therapist Other \_\_\_\_\_

Is a doctor currently seeing you? \_\_\_\_Yes \_\_\_\_No

If Yes, by whom? \_\_\_\_\_

Goals of Treatment \_\_\_\_\_

**Are you taking any of the following medications?**

____Nerve Pills	____Pain Killers (or aspirin)	____Muscle Relaxers
____Insulin	____Stimulants	____Blood Thinners
____Hormones	____Birth Control	____Other _____

Are you wearing: \_\_\_\_Heel Lifts \_\_\_\_Arch Supports

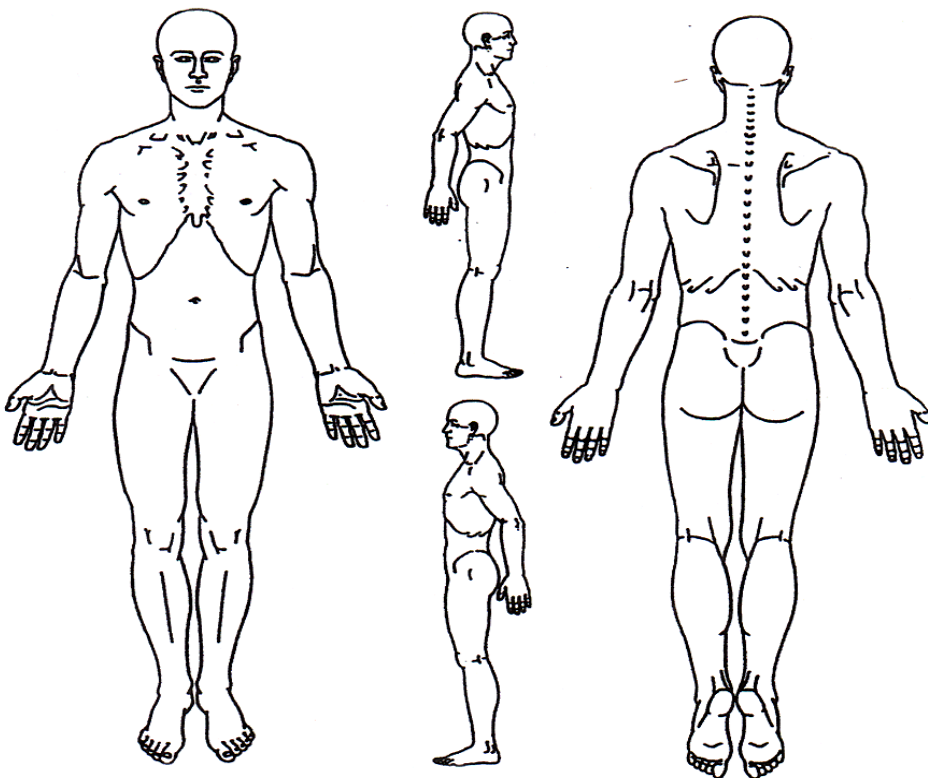
**Are any of the following in your family history?**

____Caner	____Scoliosis	____Stroke
____Diabetes	____Heart Disease	____Blood Disease
____Blood Disease	____Multiple Sclerosis	____Other _____



Indicate on the diagrams below the location/s and type of sensation/s you have been experiencing. Use the letters below to indicate the type of sensation. If the letters don't describe the sensation, write in your description of what you are feeling.

A - Ache	B - Burning	Co - Constrictive	C - Cramping	Cu - Cutting
D - Dull	N - Numbness	P - Pounding	S - Sharp	SH - Shooting
Sp - Spasm	St - Stinging	T - Tingling	TH - Throbbing	
O-Other _____				



### Recreational Activities:

Sports \_\_\_\_\_ How Often \_\_\_\_\_

Exercise \_\_\_\_\_ How Often \_\_\_\_\_

Hobbies \_\_\_\_\_ How Often \_\_\_\_\_



**Surgeries (please list the surgery and the year it was done)**

**Accidents (pleases list brief description and the year it happened)**

**Fractures (please list what was fractured and the year it happened)**

**Medical Conditions (Circle all that apply):**

Alcoholism	Eczema	Pneumonia	Small Pox
Allergies	Epilepsy	Polio	Tuberculosis
Anemia	Heart Attach	Rheumatic	Typhoid Fever
Appendicitis	Hemophilia	Fever	Whooping
Arthritis	Hepatitis	Scarlet Fever	Cough
Cancer	Kidney Disease	Scoliosis	Other_____
Chicken Pox	Liver Disease	Sexually	None
Depression	Mumps	Transmitted	
Diabetes	Pleurisy	Disease	

<b>Cigarettes</b>	None	Light	Moderate	Heavy	Amount_____
<b>Alcohol</b>	None	Light	Moderate	Heavy	Amount_____
<b>Recreational Drugs</b>	None	Light	Moderate	Heavy	Amount_____

**Signature\_\_\_\_\_Date\_\_\_\_\_**

## NECK BOURNEMOUTH QUESTIONNAIRE

**Instructions:** The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain

Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference

Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference

Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious

Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed

Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse

Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it

No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS: \_\_\_\_\_

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Examiner \_\_\_\_\_

Date \_\_\_\_\_

Score \_\_\_\_\_ (70)



## BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Instructions:** The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain											Worst pain possible
0	1	2	3	4	5	6	7	8	9	10	

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference											Unable to carry out activity
0	1	2	3	4	5	6	7	8	9	10	

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference											Unable to carry out activity
0	1	2	3	4	5	6	7	8	9	10	

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious											Extremely anxious
0	1	2	3	4	5	6	7	8	9	10	

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed											Extremely depressed
0	1	2	3	4	5	6	7	8	9	10	

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse											Have made it much worse
0	1	2	3	4	5	6	7	8	9	10	

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it											No control whatsoever
0	1	2	3	4	5	6	7	8	9	10	

\_\_\_\_\_  
Examiner

**OTHER COMMENTS:** \_\_\_\_\_