# PATIENT REGISTRATION

## PATIENT INFORMATION

Date________________________________________

SS#:___________________________ File #__________

Patient Name_______________________________

E-mail_____________________________________

Address____________________________________

City_______________________________________

State___________________________ Zip__________

Sex: ☐ Male ☐ Female Age________________

Birthdate:__________________________________

Employer__________________________________

Occupation_________________________________

Spouse's Name______________________________

Spouse's Employer___________________________

Who referred you?___________________________

Name of family physician______________________

May we contact them regarding your health? ☐ Yes ☐ No

## INSURANCE INFORMATION

Who is responsible for this account?_____________________

Relationship to patient____________________________

Insurance Co.:_________________________________

Group #:__________________ ID#__________________

Are you covered by additional insurance? ☐ Yes ☐ No

Secondary Insurance Co.:__________________________

## ACCIDENT INFORMATION

Injury due to an accident? ☐ Yes ☐ No

If yes, Date of accident ____________________________

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

Have you made a report of your accident? ☐ Yes ☐ No

To Whom? ☐ Auto Insurance ☐ Employer ☐ Workers' Comp

☐ Other ______________________________________

Attorney Name (if applicable)_________________________

## PHONE NUMBERS & EMERGENCY CONTACT

Home______________________ Work ______________________ Cell______________________ Best time to reach____________

***Emergency Contact Information***

Name__________________________ Relationship_____________ Home____________________ Work ____________________

## PATIENT CONDITION (HPI)

Reason for visit_____________________________________________________________

When did your symptoms start?______________________________

*(Please mark your areas of pain)*

How did your problem start?_______________________________

Rate your pain level **today:** (please circle one)

0 1 2 3 4 5 6 7 8 9 10

***No Pain*** ***Severe Pain***

Is your pain? ☐ Constant **(100% of day)** ☐ Frequent **(75% of day)** ☐ Occasional **(50% of day)** ☐ Intermittent **(25% of day)**

Describe the pain: ☐ Sharp ☐ Dull ache ☐ Shooting ☐ Burning ☐ Throbbing ☐ Stabbing ☐ Numbness ☐ Tingling

Is your condition? ☐ Getting Better ☐ Staying the same ☐ Getting Worse

Does it interfere with? ☐Work ☐Sleep ☐Recreation ☐Daily Activity ☐Nothing

What makes you worse? ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying down

What makes you better? ☐Nothing ☐Rest ☐Activity ☐Heat ☐Cold ☐Medication

What tests have you had? ☐X-rays ☐MRI ☐EMG ☐Ultrasound ☐Lab work

What treatment have you had? ☐Drugs ☐Nerve blocks ☐PT ☐Surgery

Has the treatment helped? ☐Yes ☐No

Have you ever had this problem before? ☐Yes ☐No

**PATIENT NAME:** **FILE #:**

## SOCIAL HISTORY

| Marital Status | Use of Alcohol | Use of Tobacco | Work Activity | Exercise Activity |
|---|---|---|---|---|
| ☐ Single | ☐ Never | ☐ Never | ☐ Sitting | ☐ None |
| ☐ Married | ☐ Occasionally | ☐ Previously, but quit | ☐ Standing | ☐ Light |
| ☐ Divorced / Separated | ☐ Moderately | ☐ Currently | ☐ Light labor | ☐ Moderate |
| ☐ Widowed | ☐ Daily | _____ Packs per day | ☐ Heavy labor | ☐ Strenuous |

## PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS *please check ☑ any that apply to you*

**Constitutional** ☐ None
☐ Bad general health
☐ Recent weight change
☐ Fever
☐ Fatigue
☐ Headaches

**Eyes** ☐ None
☐ Eye disease/injury
☐ Glasses or contact lens
☐ Blurred / double vision

**Ear/Nose/Throat** ☐ None
☐ Hard of Hearing
☐ Ringing in ears
☐ Vertigo
☐ Sinus problems
☐ Nose bleeds
☐ Sore throat / voice change
☐ Swollen glands

**Neurological** ☐ None
☐ Seizures or Epilepsy
☐ Numbness / Tingling
☐ Tremors
☐ Stroke

**Musculoskeletal** ☐ None
☐ Joint Pain / Stiffness
☐ Joint Swelling
☐ Arthritis
☐ Osteoporosis
☐ Chronic fatigue
☐ Fibromyalgia

**Cardiovascular** ☐ None
☐ Chest pain / Palpitations
☐ Dizziness / Fainting
☐ Shortness of breath
☐ Swelling in hands / feet
☐ High blood pressure
☐ High cholesterol
☐ Heart attack
☐ Congestive heart failure

**Gastrointestinal** ☐ None
☐ Heartburn
☐ Nausea/Vomitting
☐ Diarrhea/Constipation
☐ Blood in stools
☐ Gall bladder problems
☐ Liver problems
☐ Ulcers

**Urinary** ☐ None
☐ Pain / Difficulty urinating
☐ Blood in urine
☐ Incontinence
☐ Kidney stones
☐ Kidney problems

**Respiratory** ☐ None
☐ Cough
☐ Congestion
☐ Wheezing
☐ Asthma
☐ Emphysema
☐ Pneumonia

**Psychologic** ☐ None
☐ Anxiety / Depression
☐ Mood Swings
☐ Difficulty sleeping
☐ Memory loss

**Hematologic** ☐ None
☐ Slow to heal after cuts
☐ Bleed or bruise easily
☐ Anemia
☐ Enlarged glands

**Endocrine** ☐ None
☐ Excessive thirst / urination
☐ Heat or cold intolerance
☐ Skin becoming drier
☐ Diabetes
☐ Thyroid disorder

**Skin** ☐ None
☐ Rash / Sores
☐ Lesions
☐ Breast pain or lump
☐ Dermatitis / Eczema

**Allergic/Immune** ☐ None
☐ Food allergies
☐ Airborne allergies
☐ Systemic Lupus
☐ Cancer
☐ HIV/AIDS

***FEMALES ONLY***
☐ I may be pregnant
☐ I take birth control pills

## FAMILY HISTORY

| | Living? | | Rheumatoid Arth | | Cancer | | Diabetes | | Heart Problems | | Back Problems | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No |
| Father | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mother | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Brothers/Sisters | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## LIST HOSPITALIZATIONS AND SURGERIES

Falls________________________________________________

Fractures ____________________________________________

Hospitalizations_______________________________________

Surgeries_____________________________________________

## MEDICATIONS

☐ None
☐ Nerve Pills ☐ Pain Killers ☐ Anti-Inflamm.
☐ Muscle Relaxers ☐ Anti-Depressants
☐ BP Medication ☐ Heart Meds.
☐ Insulin ☐ Allergy Meds.
☐ Other:_____________________________________

## SUPPLEMENTS

☐ None
☐ Multi Vit/Min
☐ Calcium
☐ Glucosamine
☐ Omega 3 Oils
☐Other:____________________

## ALLERGIES

1.
2.
3.
4.
5.

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the clinic any changes in my medical status.

_______________________________________ _______________ **Reviewed by:**________________________

**Novelli Chiropractic Clinic ◆ 525 North Main Street ◆ North Canton, OH 44720 ◆ 330-497-1942**

**Signature of Patient or Parent of Minor** **Date**