Advance Performance Pain and Wellness center

Insurance provider: ___________________

CHIROPRACTIC REGISTRATION AND HISTORY

Name____Sex M F Date ___/___/_____
Address____State_____________Zip____________________
Best Phone:__________________Email:______________________________ Date of Birth: ___/___/____ Age____________
Employer____Occupation____________________________________
Whom may we thank for referring you?____
Have you ever received Chiropractic Care? Yes No If yes, when?____

CHIEF COMPLAINT

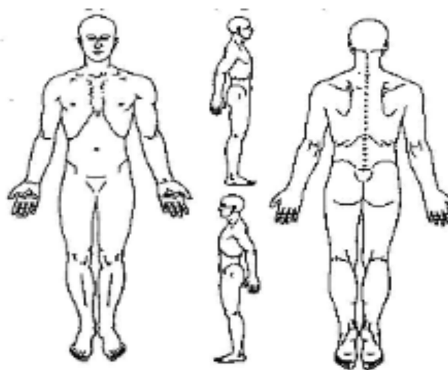
Reason for Visit____

Location of Complaint:____

Complaint Began when and how?____

Please circle the Quality of the complaint/pain:

dull aching sharp shooting burning throbbing deep nagging numbness swelling stiffness tingling other ________



Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?

____

Do you have any numbness or tingling in your body? Where?

____

How frequent is complaint present, how long does it last?

____

Grade Intensity/Severity: (use chart below)

(No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

Does anything aggravate the complaint?____

Does anything make the complaint better?____

Anything associated with the pain?____

PREVIOUS TREATMENTS, MEDICATIONS, SURGERY, OR CARE FOR YOUR COMPLAINT

Ice: Yes No Did it help? _______ Heat: Yes No Did it help?_______ Stretching: Yes No Did it help? _______

Over the Counter Medications:____ Did they help?_________________

Other:____

Surgery?: ____ Physical Therapy?___________________________________

Name and Address of Doctor(s) who have treated you for this condition:____
____
____

PAST HEALTH HISTORY

Date of Last:
Physical:____ Blood Test:____
Spinal X-ray:_______________________________________ MRI, CT, DEXA scan:_____________________________________

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Please place an X on the YES or NO to indicate if you have had any of the following:

Disease/Condition	YES	NO	Disease/Condition	YES	NO	Disease/Condition	YES	NO
AIDS/HIV			Chicken Pox			Liver disease		
Alcoholism			Diabetes			Measles		
Allergy Shots			Emphysema			Migraine Headaches		
Anemia			Venereal Disease			Glaucoma		
Appendicitis			Goiter			Miscarriage		
Arthritis			Gonorrhea			Osteopenia/Osteoporosis		
Asthma			Epilepsy			Mononucleosis		
Bleeding disorders			Gout			Multiple Sclerosis		
Breast Lump			Heart disease			Mumps		
Bronchitis			Hepatitis			Whooping Cough		
Bulimia/Anorexia			Hernia			Parkinson's disease		
Cancer			Cataracts			Chemical Dependency		
Herniated Disc			Pinched Nerve			Herpes		
High Cholesterol			Kidney Disease			Pneumonia		
Vaginal Infections			Prostate Problems			Ulcers		
Psychiatric care			Rheumatoid Arthritis			Rheumatic Fever		
Scarlet fever			Stroke			Suicide Attempt		
Thyroid problems			Tonsilitis			Tumors/Growths		

Other:____

____

Have you ever broken any bones? Which?____

Have you had any Concussions? When?____

Have you had any falls? When?: ____

ALLERGIES

Allergy	Reaction

MEDICATIONS:

Medication	Reason For Taking	Dose

SUPPLEMENTS

Supplement	Brand

SURGERIES

Surgery:	Date:

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FEMALE ONLY

Pregnancy/Date of Delivery	Outcome

What was the date of the beginning of your last menstrual period? ____

Date of your last PAP Smear:____

PHYSICAL AND TRAUMA INFORMATION

Work Activities: SITTING STANDING LIGHT LABOR HEAVY LABOR RETIRED_________________________________

Work Injuries: YES NO If yes:____

Sports Injuries: YES NO If yes:____

Exercise: NONE LIGHT MODERATE HEAVY ____

Falls: YES NO If yes:____

Head Injuries: YES NO If yes:____

FAMILY HEALTH HISTORY

Family History of:

Disease/Condition:	Family Member	If Deceased Age of Death
Heart Disease		
Cancer		
Diabetes		
Stroke		
Neuromuscular Disease		
Dementia/Alzheimers		

SOCIAL AND OCCUPATIONAL HISTORY

Job description:____

Recreational activities:____

Lifestyle (hobbies, level of exercise, alcohol, and drug use, diet):____

____

Days that work best with your schedule: M T W Th F S

Smoker: YES NO If yes: How many packs/day?_________ Number of years as a smoker?___________________________

GOALS

Health Goals you would like to discuss further with the doctor:

1. ____
2. ____
3. ____

INFORMED CONSENT

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature ____ Date ____/____/__________

Doctors Signature ____ Date ____/____/__________