CHIROPRACTIC REGISTRATION AND HEALTH HISTORY FORM

Northwestern Medicine

PATIENT INFORMATION

Patient Name: _____ Today's Date: _____

Address: _____

Email _____ Birthdate _____

PHONE NUMBERS

Cell/Mobile: _____ Home: _____ Best time to reach you: _____

Emergency Contact Name: _____ Relation: _____ Phone: _____

ACCIDENT INFORMATION *(Please fill if applicable)*

Is this condition due to an accident? YES ☐ NO ☐ *If yes, please complete a personal injury form*

PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

Is your condition worsening over time? _____

Have you seen other doctors for this complaint? YES ☐ NO ☐ *If answered yes, please list below*

Doctor's Name: _____

Please rate the severity of your pain *(from 1-10, with 10 being the worst)* _____

Is it constant or does it come and go? _____

How often does it come and go? _____

Does it interfere with your: work ☐ sleep ☐ daily routines ☐ recreation ☐

Activities which are painful: standing ☐ sitting ☐ lying down ☐ walking ☐ bending ☐

HEALTH HISTORY

WHAT WAS THE DATE OF YOUR LAST:

Physical Exam: _____ Spinal Exam: _____MCT/bone scan: _____

Spinal X-ray: _____ Blood/Urine test: _____

Please mark with an "X" to indicate if you have/had any of the following. Please also mark any that apply to your immediate family, and indicate relationship to you.

- ☐ AIDS/HIV *family?*_____
- ☐ Alcoholism *family?*_____
- ☐ Allergy Shots *family?*_____
- ☐ Anemia *family?*_____
- ☐ Anorexia *family?*_____
- ☐ Appendicitis *family?*_____
- ☐ Arthritis *family?*_____
- ☐ Asthma *family?*_____
- ☐ Bleeding Disorders *family?*_____
- ☐ Breast Lump *family?*_____
- ☐ Bronchitis *family?*_____
- ☐ Bulimia *family?*_____
- ☐ Cancer *family?*_____
- ☐ Cataracts *family?*_____
- ☐ Chemical Dependency *family?*_____
- ☐ Diabetes *family?*_____
- ☐ Emphysema *family?*_____
- ☐ Epilepsy *family?*_____
- ☐ Goiter *family?*_____
- ☐ Gout *family?*_____
- ☐ Heart Disease *family?*_____
- ☐ Hepatitis *family?*_____
- ☐ Hernia *family?*_____
- ☐ Herniated Disc *family?*_____
- ☐ High cholesterol *family?*_____
- ☐ Kidney Disease *family?*_____
- ☐ Liver Disease *family?*_____
- ☐ Migraines *family?*_____
- ☐ Miscarriage *family?*_____
- ☐ Multiple Sclerosis *family?*_____
- ☐ Osteoporosis *family?*_____
- ☐ Pacemaker *family?*_____
- ☐ Parkinson's *family?*_____
- ☐ Polio *family?*_____
- ☐ Prostate Problems *family?*_____
- ☐ Prosthesis *family?*_____
- ☐ Psychiatric Care *family?*_____
- ☐ Stroke *family?*_____
- ☐ STD *family?*_____
- ☐ Suicide Attempts *family?*_____
- ☐ Thyroid Problem *family?*_____
- ☐ Tonsillitis *family?*_____
- ☐ TB Tumors *family?*_____
- ☐ Ulcers *family?*_____
- ☐ Other *family?*_____

ADDITIONAL INFORMATION

EXERCISE: None ☐ Mild ☐ Moderate ☐ Heavy ☐

WORK HABITS: Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐

OTHER HABITS: ☐ Smoking *quantity?*_____ ☐ Drinking *quantity?*_____
☐ Coffee/Caffeine *quantity?*_____ ☐ Stress *quantity?*_____

Pregnancy History: ***(please fill if applicable)***

Number of: pregnancies _____ miscarriages _____ live births _____

Vaginal or C-section? _____ Are you pregnant now? _____expected due date: _____

Injuries and Surgeries: Please describe major injuries and any surgical procedures performed, and approximate dates

_____
_____
_____
_____

Medications:

Please list medications, what they are for, and how long you have been taking them

_____
_____
_____
_____
_____
_____

Allergies *(if any)*:

_____
_____
_____
_____
_____
_____

Supplements:

Please list supplements you are currently taking, where you purchased them, and the dose (if known)

_____
_____
_____
_____
_____
_____

Patient Goals and Expectations: *Please tell us your goals and expectations for your care*

☐ Relief care – primary goal is to relieve your symptoms
☐ Corrective Care – complete the corrective treatment begun in the relief care
☐ Stabilization – stabilize the structures supporting the spine to prevent future episodes
☐ Wellness – promotion of optimal functioning of overall bodily systems
☐ Other: _____

_____