

Corrective Chiropractic

Patient Registration

Patient Contact

Title: Mr./Mrs./Ms./Dr./Rev./Rank _____ Date _____

Last Name _____ First Name _____ M.I. _____

Preferred To Be Called/Nickname _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

Work Phone _____ E-Mail _____

Patient Personal

Age _____ Date of Birth _____ Gender: Male Female

Social Security # _____ Drivers License #/State _____

Employer Name _____ Occupation _____

Marital Status: Single Married Widowed Separated Divorced

Name of Spouse _____ Employer _____ Phone _____

Children (names, ages) _____

Emergency Contact

Name _____ Relationship _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Are you here because you were in an auto accident? Yes No

Are you here because you were injured at work? Yes No

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Injury Information

Date of collision/injury _____ Approximate time _____ AM / PM

Did you go to the Emergency Room? (Yes / No) If yes, in an ambulance? (Yes / No)

Name of the Hospital Emergency Room: _____

List any medications that you were given: _____

List any instructions that you were given: _____

From the following list, circle the treatment(s) that you received at the Emergency Room:

Exam / X-Ray / MRI / CT Scan / Back Brace / Neck Brace / Home Instructions / Other _____

List all the doctors (other than at the ER) that you have seen as a result of your injuries:

1. _____ What Treatment? _____

2. _____ What Treatment? _____

3. _____ What Treatment? _____

Are you experiencing any of the following since the injury?

<input type="checkbox"/> Fever/Weight loss	<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Headache
<input type="checkbox"/> Dizziness/Loss of balance/Nausea	<input type="checkbox"/> Breathing problems	<input type="checkbox"/> Rapid heartbeat	<input type="checkbox"/> Indigestion
<input type="checkbox"/> Anxiety/Irritability/Memory lapses	<input type="checkbox"/> Urinary difficulties	<input type="checkbox"/> Skin problems	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Allergic/Immunological disorders	<input type="checkbox"/> Blood/Lymph disorders	<input type="checkbox"/> Hot/Cold flashes	

Were you off work as a result of your injuries? (Yes / No) If yes, from _____ to _____

What type of physical effort is required in your line of work? _____

Does your work aggravate your pain? (Yes / No / Somewhat)

Patient Signature _____ Date _____

Guardian Signature (if applicable) _____ Date _____