WHITWORTH CHIROPRACTIC

500 S. Cherry St.
Tomball, TX 77375
P: (832) 761-0124

PATIENT REGISTRATION AND HISTORY

TODAY'S DATE: _____

PATIENT INFORMATION:

TITLE: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.

NAME: _____ _____ _____
Last Name First Name Middle Initial

DATE OF BIRTH: _____/_____/_____ GENDER: ☐ Male ☐ Female
month day year

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PRIMARY PHONE: _____ CELL PHONE: _____

EMAIL: _____ PREFERRED CONTACT: ☐ Primary Phone ☐ Mobile Phone ☐ Email

MARTIAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBER: _____

REFERRAL SOURCE: ☐ Person (name) _____ ☐ Internet ☐ Doctor's office _____ ☐ Other _____

HEALTH HISTORY

LIST CURRENT MEDICATIONS (Please include over-the-counter medications, vitamins/minerals, herbs or other supplements)

_____

ALLERGIES _____

DO YOU SMOKE? ☐ Yes ☐ No ☐ Former Smoker Packs per day _____

DRINK ALCOHOL? ☐ Yes ☐ No Drinks per day _____

COFFEE/CAFFEINE DRINKS? ☐ Yes ☐ No Cups per day _____

EXERCISE: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

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

DATE OF LAST PHYSICAL EXAM: _____ ☐ Blood work ☐ Urine Test ☐ X-Ray

NAME OF PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER: _____

FEMALE PATIENTS: Are you currently pregnant? ☐ Yes ☐ No Date of last menstrual cycle: _____

HAVE YOU BEEN HOSPITALIZED? ☐ Yes ☐ No If yes, please explain _____

PREVIOUS SURGERIES? ☐ Yes ☐ No If yes, please explain _____

Please mark "Yes" or "No" to indicate if you have had or currently have any of the following. Please mark "Family" if there is a family history of the condition.

AIDS/HIV ☐ Yes ☐ No ☐ Family	Emphysema ☐ Yes ☐ No ☐ Family	Muscular Dystrophy ☐ Yes ☐ No ☐ Family
Alcoholism ☐ Yes ☐ No ☐ Family	Epilepsy ☐ Yes ☐ No ☐ Family	Osteoporosis ☐ Yes ☐ No ☐ Family
Allergies ☐ Yes ☐ No ☐ Family	Diverticulitis ☐ Yes ☐ No ☐ Family	Pacemaker ☐ Yes ☐ No ☐ Family
Anemia ☐ Yes ☐ No ☐ Family	Gout ☐ Yes ☐ No ☐ Family	Parkinson's ☐ Yes ☐ No ☐ Family
Appendicitis ☐ Yes ☐ No ☐ Family	Headaches ☐ Yes ☐ No ☐ Family	Pins/Screws, Plates ☐ Yes ☐ No ☐ Family
Arthritis ☐ Yes ☐ No ☐ Family	Heart Disease ☐ Yes ☐ No ☐ Family	Prostate Problems ☐ Yes ☐ No ☐ Family
Asthma ☐ Yes ☐ No ☐ Family	Herniated Disc ☐ Yes ☐ No ☐ Family	Psychiatric Care ☐ Yes ☐ No ☐ Family
Bleeding Disorders ☐ Yes ☐ No ☐ Family	Hernia ☐ Yes ☐ No ☐ Family	Rheumatoid Arthritis ☐ Yes ☐ No ☐ Family
Bone Fracture ☐ Yes ☐ No ☐ Family	High Blood Pressure ☐ Yes ☐ No ☐ Family	Rheumatic Fever ☐ Yes ☐ No ☐ Family
Cancer ☐ Yes ☐ No ☐ Family	High Cholesterol ☐ Yes ☐ No ☐ Family	Scoliosis ☐ Yes ☐ No ☐ Family
Chicken Pox ☐ Yes ☐ No ☐ Family	Kidney Disease ☐ Yes ☐ No ☐ Family	Sleeping Issues ☐ Yes ☐ No ☐ Family
Concussion ☐ Yes ☐ No ☐ Family	Liver Disease ☐ Yes ☐ No ☐ Family	Spinal Disc Problems ☐ Yes ☐ No ☐ Family
Diabetes ☐ Yes ☐ No ☐ Family	Low Blood Pressure ☐ Yes ☐ No ☐ Family	Thyroid Disorder ☐ Yes ☐ No ☐ Family
Dislocated Joint ☐ Yes ☐ No ☐ Family	Migraine Headaches ☐ Yes ☐ No ☐ Family	Tuberculosis ☐ Yes ☐ No ☐ Family
Eating Disorder ☐ Yes ☐ No ☐ Family	Multiple Sclerosis ☐ Yes ☐ No ☐ Family	Tumors ☐ Yes ☐ No ☐ Family
Sinus Problems ☐ Yes ☐ No ☐ Family	Ulcers ☐ Yes ☐ No ☐ Family	Weight Changes ☐ Yes ☐ No ☐ Family
Venereal Disease ☐ Yes ☐ No ☐ Family	Other _____	

If items marked "Yes" above, please explain: _____

_____

CHIEF COMPLAINT:

Reason for visit: _____

When did your symptoms start? _____ Is this condition work-related or auto-injury? ☐ Yes ☐ No

Are the symptoms getting: ☐ Progressively worse ☐ Staying the same ☐ Better

Type of Pain: ☐ Sharp ☐ Dull/Aching ☐ Throbbing ☐ Numbness ☐ Shooting ☐ Burning
☐ Tingling ☐ Cramps ☐ Other _____

Is the pain constant of does it come and go? _____ How frequent? _____

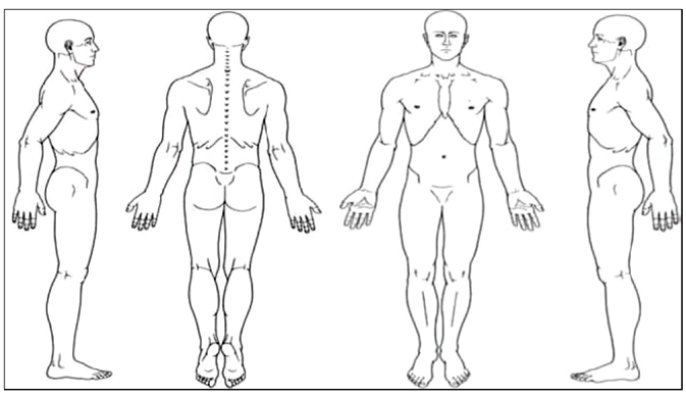
What treatments have you already tried for your condition? ☐ Medications ☐ Physical therapy ☐ Heat/Ice ☐ Massage ☐ Rest
☐ Other _____

Have you had this condition before? ☐ Yes ☐ No If yes, did you receive treatment? ☐ Yes ☐ No If yes, please explain:

_____

Have you had an X-ray, CT scan or MRI? ☐ Yes ☐ No If yes, explain _____

Please circle your CURRENT pain level: No pain – 0 1 2 3 4 5 6 7 8 9 10 – Worst pain



Please mark the areas on the diagram where you have pain, numbness or tingling.

PATIENT SIGNATURE: _____ **DATE:** _____