

REGISTRATION AND HISTORY

Patient Information

Name _____
Address _____
Phone _____
 Home Work Cell
Email _____
Occupation _____
Employer _____
Employer Address _____
Employer Phone _____
How Did You Hear About Us? _____

Date _____
City _____ State _____ Zip _____
Best Time and Place to Call _____
Sex _____ Age _____ Birthdate _____
Relationship Single Married Partnered
 Divorced Widowed
Partner/Parent Name _____
Partner/Parent Occupation _____
Partner/Parent Employer _____

Emergency Contact Information

Name _____

Relationship _____ Phone _____

Insurance

Name on Account _____
Insurance Co _____

Relationship to Patient _____
Group # _____ ID # _____

How Can We Help You?

Reason for today's visit _____

Is your appointment today related to: Job Auto Accident

If yes, have you made a report of your injury to your: Employer Insurance Company

Please list your complaints. List them by number with the first being the most severe and give it a rating of 1-10 (10 being most severe)

1. Complaint _____ Severity Rating _____

When did symptoms appear? _____ Is this condition getting progressively worse? _____

Type of discomfort: Sharp Dull Throbbing Aching Shooting Numbness Burning
 Tingling Cramps Stiffness Swelling Other

Does it interfere with your: Work Sleep Recreation

Activities that are difficult to perform _____

2. Complaint _____ Severity Rating _____

When did symptoms appear? _____ Is this condition getting progressively worse? _____

Type of discomfort: Sharp Dull Throbbing Aching Shooting Numbness Burning
 Tingling Cramps Stiffness Swelling Other

Does it interfere with your: Work Sleep Recreation

Activities that are difficult to perform _____

3. Complaint _____ Severity Rating _____

When did symptoms appear? _____ Is this condition getting progressively worse? _____

Type of discomfort: Sharp Dull Throbbing Aching Shooting Numbness Burning
 Tingling Cramps Stiffness Swelling Other

Does it interfere with your: Work Sleep Recreation

Activities that are difficult to perform _____

What Services Do You Seek?

Chiropractic Care Previous Care _____



HAKA
SPORTS CLINIC

Active Release Technique Other

Health Habits

Current Exercise (Type/ # Times Per Week) _____

Tobacco Usage (How Often) _____ Alcohol Consumption (How Often) _____

Caffeine Consumption (How Often) _____ Orthotics Usage (Type/ How Long) _____

Current Medications (Please List Both Prescription and Over-the-Counter) _____

Current Vitamins or Supplements (Please List) _____

Health Conditions

Please check any of the following diseases or conditions that you now have or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- | | | |
|---|--|---|
| <input type="checkbox"/> Severe or Frequent Headaches | <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> PID |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Congenital Heart Defects | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Concussion/Head Injury | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Vision Impairment |
| <input type="checkbox"/> Loss of Sleep/Irregular Sleep Patterns | <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Jaw Discomfort | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Pain Between the Shoulders | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Numbness/Pain in Arms/Hands/Legs | <input type="checkbox"/> Degen./Rheumatoid Arthritis | <input type="checkbox"/> Joint Dislocation |
| <input type="checkbox"/> Muscle Spasms/Cramps | <input type="checkbox"/> Tendonitis/Bursitis | <input type="checkbox"/> Fracture |
| <input type="checkbox"/> Sprains (Please Specify _____) | <input type="checkbox"/> Surgery (Please Specify _____) | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> Bone and Joint Disease | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Skin Disorders | <input type="checkbox"/> Anemia | <input type="checkbox"/> Weight Change |
| <input type="checkbox"/> Memory Loss (Short/Long Term) | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Verereal Disease |
| <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Vaccinations (Type/Date _____) | |

For Women

- | | | |
|---|---|--|
| <input type="checkbox"/> Pregnancy (Trimester _____) | <input type="checkbox"/> Nursing | <input type="checkbox"/> Birth Control (Type _____) |
| <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Irregular Cycles | <input type="checkbox"/> Breast Implants/Reduction |

