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# Patient Registration Form

Date ______________

Name ______________________________ Home Phone ______________

Address ______________________________ Work Phone ______________

City ______________ State ________ Zip ________ Email ______________

Date of Birth ______________ | ○ Male ○ Female | ○ Single ○ Married ○ Divorced ○ Widowed

Social Security ______________________ Driver License ______________

Employer ______________________ Occupation ______________

Employer Address ______________________ Private Physician ______________

City ______________ State ________ Zip ________ Referred by ______________

Emergency Contact ______________________ Contact Phone ______________

**Please circle "Y" for yes or "N" for no**

| Question | | |
|---|---|---|
| Do you experience vertigo (dizziness)? | Y | N |
| Do you pass out easily (faint, lose consciousness)? | Y | N |
| Do you have double vision or have you lost sight in one eye? | Y | N |
| Do you have any slurred speech or difficulty speaking? | Y | N |
| Do you have or have you ever had difficulty arranging words properly? | Y | N |
| Have you experienced any difficulty walking, with coordination or falling to one side? | Y | N |
| Do you experience nausea or vomiting? | Y | N |
| Do you have numbness on one side of your face or body? | Y | N |
| Do you have any visual disturbances or rapid eye movement? | Y | N |
| Do you get headaches or experience head pain unlike any you have had before? | Y | N |
| Do you experience headaches for hours or days? | Y | N |
| Do you have a history of stroke in your family? | Y | N |
| Do you have chest pain? | Y | N |
| Have you experienced any change in bowel or bladder habits? | Y | N |
| Do you have a sore that won't heal? | Y | N |
| Do you have any unusual bleeding or discharge? | Y | N |
| Do you have indigestion or difficulty swallowing? | Y | N |
| Have you noticed any change in any wart or mole? | Y | N |
| Do you have a nagging cough or hoarseness? | Y | N |
| Do you have night sweats? | Y | N |
| Do you have pain in your neck, jaw or face? | Y | N |
| Do you have a drooping eyelid or have you experienced any change in your pupils? | Y | N |
| Do you have any ringing in your ears? | Y | N |
| Do you take birth control pills? | Y | N |
| Are you currently pregnant? | Y | N |

What prescription medication are you taking if any?

○ High blood pressure medication ○ Herb, vitamins or over the counter products ______________

○ Blood thinners ○ Other ______________

(continued on back)

**Please circle "Y" for yes or "N" for no**

| | | |
|---|---|---|
| Have you ever had cancer? | Y | N |
| Does your pain ever wake you from a sound sleep? | Y | N |
| Are you losing weight now without trying? | Y | N |
| Are you coughing up blood or noticing it in your stool or urine? | Y | N |
| Have you had any loss of bladder or bowel control? | Y | N |
| Are you currently seeing any other doctor now for any reason? | Y | N |
| If yes, what reason ______ | | |
| Do you have allergies? | Y | N |
| If yes, please list ______ | | |
| Are you allergic to any medications? | Y | N |
| If yes, please list ______ | | |

What is your present complaint? ______

______

Do you exercise regularly? Y N

Do you smoke? Y N
If yes, how many packs a day?______

Do you drink alcohol? Y N
If yes, how much? ______

Did your mother or father have any of the following:
**(Please put an "M" for mother, "F" for father or "B" for both)**

_____ High Blood Pressure
_____ Ulcer or Stomach Problems
_____ Heart Attack
_____ Emphysema
_____ Seizures/Convulsions
_____ Arthritis/Rheumatism
_____ HIV Positive
_____ Mental Illness
_____ Asthma
_____ Thyroid Disease
_____ Diabetes
_____ Circulation Problems
_____ Kidney Disease
_____ Cancer
_____ Stroke (please indicate age when stroke occurred)
_____ Mother _____ Father

Additional Comments ______

______

______

______

Please use the letters listed below to indicate the *type* and *location* of your pain and sensations.

**Key**

**A** = Ache
**B** = Burning
**S** = Stabbing
**N** = Numbness
**P** = Pins & Needles

**Neck / Shoulder / Arm Pain**
On a scale of 0-10, I rate my discomfort as follows:

(______)
0 no pain — 10 severe pain

**Mid Back Pain**
On a scale of 0-10, I rate my discomfort as follows:

(______)
0 no pain — 10 severe pain

**Low Back and Leg Pain**
On a scale of 0-10, I rate my discomfort as follows:

(______)
0 no pain — 10 severe pain

Patient Signature ______ Date ______