Dr. Janet McGaurn
Family Chiropractor

Patient Registration and History

Referred by________________________________

Date________________________________

PATIENT INFORMATION

Name________________________________ Sex: ❑ M ❑ F

Date of Birth________________________________ Age ____________

Address________________________________
STREET CITY STATE ZIP

Phone (home)____________________ (work)____________________ (cell)____________________

Email________________________________

Occupation____________________Employer ____________________

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Spouse's Name____________________ Spouse's Occupation ____________________

Number of Children and Ages: Previous Chiropractic Care?

Name____________________ Age______ ❑ Yes ❑ No Reason____________________

Name____________________ Age______ ❑ Yes ❑ No Reason____________________

Name____________________ Age______ ❑ Yes ❑ No Reason____________________

Name____________________ Age______ ❑ Yes ❑ No Reason____________________

INSURANCE (*Please show your insurance card to the Chiropractic Assistant at the front desk)*

Who is responsible for this account____________________Relationship to patient ______________

CURRENT CONDITION

Reason for today's visit________________________________

When did major pain or problem start? ________________________________

Pains are: ❑ Sharp ❑ Dull ❑ Constant ❑ Intermittent

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

What activities aggravate your condition/pain? ________________________________

What activities lessen your condition/pain? ________________________________

Time of day the condition seems worse?________________________________

Is this condition interfering with: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation ❑ Other

Other doctors seen for this condition ________________________________

Home remedies ________________________________

Is condition due to an accident? ❑ Yes ❑ No Date ____________________

Type of accident: ❑ Auto ❑ Work ❑ Home ❑ Other

IN CASE OF EMERGENCY, CONTACT

Name________________________________ Relationship ____________________

Phone (home)____________________ (work)____________________ (cell)____________________

– OVER –

HEALTH HISTORY

Was your birth traumatic? (check all that apply) — Chiropractor's Comments

- ❑ Long delivery
- ❑ Difficult delivery
- ❑ Forceps
- ❑ Caesarean
- ❑ Breech
- ❑ Home birth
- ❑ Induced labor
- ❑ Mother given drugs during delivery

As a child, did you ever... (check all that apply)

- ❑ Breastfeed
- ❑ Fall out of bed
- ❑ Bang your head
- ❑ Have any accidents
- ❑ Have surgery
- ❑ Have a childhood sickness
- ❑ Take drugs
- ❑ Fall while learning to walk
- ❑ Have a chair pulled out when sitting
- ❑ Fall down the stairs
- ❑ Get pulled by your arm
- ❑ Experience other traumas
- ❑ Were you ever
  _Spanked _Pulled by ear/chin _Other
- ❑ Get bullied by your siblings

Did/do you... (check all that apply)

- ❑ Smoke
- ❑ Drink
- ❑ Diet
- ❑ Take drugs (prescriptive or non-prescriptive)
- ❑ Have teeth problems
- ❑ Have eye problems
- ❑ Have hearing problems
- ❑ Exercise regularly
- ❑ Have sleeping problems
- ❑ Have occupational stress
- ❑ Have physical stress
- ❑ Have mental stress
- ❑ Have hobby/sports injuries

What is your sleeping posture? ❑ side ❑ stomach ❑ back

Other symptoms? (check all that apply)

❑ Headaches	❑ Face Flushed	❑ Light Bothers Eyes	❑ Feet Cold
❑ Neck Pain	❑ Neck Stiff	❑ Loss of Memory	❑ Hands Cold
❑ Chest pains	❑ Pins & Needles in Legs	❑ Ears Ring	❑ Stomach Upset
❑ Back Pain	❑ Pins & Needles in Arms	❑ Fever	❑ Constipation
❑ Nervousness	❑ Numbness in Fingers	❑ Fainting	❑ Loss of Balance
❑ Tension	❑ Numbness in Toes	❑ Cold Sweats	❑ Diarrhea
❑ Irritability	❑ Shortness of Breath	❑ Loss of Smell	❑ Buzzing in Ear
❑ Loss of Taste	❑ Fatigue	❑ Dizziness	❑ Depression

Have you been under drug and/or medical care? ❑ Yes ❑ No

What medications are you taking? ______________________________

______________________________ How long ______________

Have you had surgery? ❑ Yes ❑ No Describe (with dates) ______________________________

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Have you had side effects from drugs or surgery? ❑ Yes ❑ No Describe ______________________________

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other______________
Father's side	❑	❑	❑	❑	❑
Mother's side	❑	❑	❑	❑	❑