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)_____

Preferred phone number? ❑ Home ❑ Work ❑ Cell Do you want appointment confirmation calls? ❑ Yes ❑ No

Email_____ Do you want to receive the email newsletter? ❑ Yes ❑ No

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 ❑ Get bullied by your siblings _____
_Spanked _Pulled by ear/chin _Other _____

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

❑ Smoke ❑ Drink ❑ Diet _____
❑ Take drugs (prescriptive or non-prescriptive) _____
❑ Have any allergies ❑ Have eye problems _____
❑ Have teeth problems ❑ Exercise regularly _____
❑ Have hearing problems ❑ Have occupational stress _____
❑ Have sleeping problems ❑ Have mental stress _____
❑ Have physical 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) _____

_____

_____

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	❑	❑	❑	❑	❑