



CHIRO-ASSOCIATES, INC.

252 Main Street
Norwell, MA 02061
781-659-1518

265 Washington Street
Abington, MA 02351
781-871-8833

PATIENT REGISTRATION

Appointment Scheduled For: _____ @ _____: _____ ☐ a.m. ☐ p.m. File # _____

PATIENT INFORMATION

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Social Security #: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

Work Phone: _____ Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time student ☐ Retired ☐ Other

Email address: _____ I consent to receive communication via texting/email from Chiro-Assoc. Yes / No

Ethnicity: ☐ Non-Hispanic ☐ Hispanic Race: ☐ Asian ☐ Black ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address of Employer: _____ City/State/Zip: _____

SPOUSE INFORMATION

Spouse's Name: _____ Date of Birth: _____

Spouse's Employer: _____ Phone: _____

INSURANCE INFORMATION

Name of Insured: _____ Insured's Date of Birth: _____ Relationship to Patient: _____

Insurance Company: _____ I.D. Number: _____

IS YOUR ILLNESS OR INJURY RELATED TO ANY OF THE FOLLOWING?

Employment (work related) ☐ Auto Accident (State of auto accident): _____ Please indicate the Date of Injury: _____

HOW WERE YOU REFERRED TO OUR OFFICE?

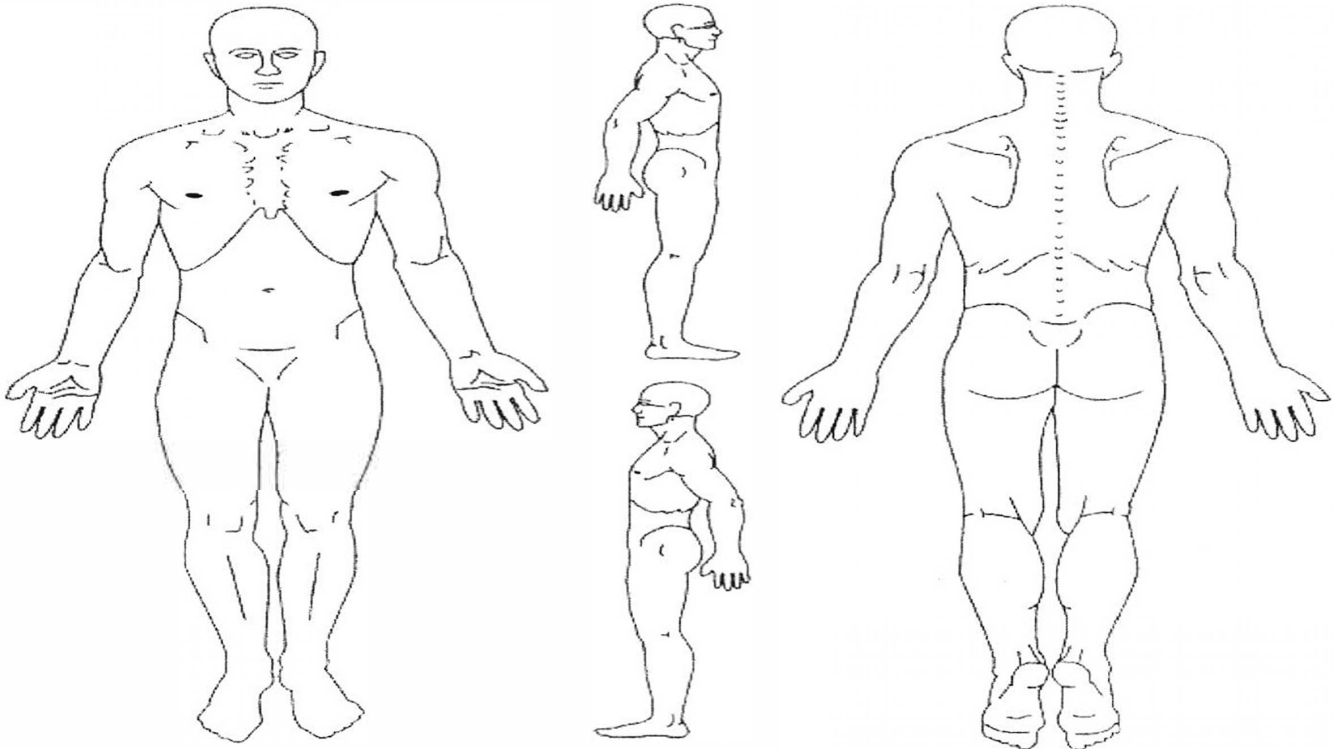
Web (Google/AOL/Yahoo) ☐ By a Doctor ☐ By an Attorney ☐ By a Patient ☐ Yellow Pages ☐ Other ☐
Who may we thank for referring you to our office? _____

Patient Signature: _____ Date: _____

Print Name: _____

Parent/Guardian (for patient under 18 years of age): _____ Date: _____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:
N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptom(s) pain - circle the intensity on a scale 1-10 (10 being the worst):

Head:	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>
Neck:	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>
Mid-Back:	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>
Lower Back:	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>
Other: _____	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>

When did your symptoms begin? Month _____ Day _____ Year _____

Are your symptoms a result of: Motor Vehicle Accident ☐ Work Related Accident ☐ Cause Unknown ☐
 Other (Please explain): _____

How often do you experience your symptoms?

Constantly ☐
 (76-100% of the day)

Frequently ☐
 (51-75% of the day)

Occasionally ☐
 (26-50% of the day)

Intermittently ☐
 (0-25% of the day)

Patient Name _____ **Date** _____

How are your symptoms changing?

Improving ☐ Unchanged ☐ Getting worse ☐

In general, are your symptom(s) better in:

AM ☐ Midday ☐ PM ☐

In general, are your symptom(s) Worse in:

AM ☐ Midday ☐ PM ☐

Do you have night pain unrelated to movement:

Yes ☐ No ☐

Do you have constant pain unrelated to movement:

Yes ☐ No ☐

My pain interferes with Daily Activities: Effects of Current Condition on Performance

Bending:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Kneeling:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Climb Stairs:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Lifting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Driving:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Extended Computer Use:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Household Chores:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Reading (Concentration):	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Self Care--Bathing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Self Care--Dressing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Sleep:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Change Posn--Sit-Stand:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Static Sitting:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Static Standing:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Walking:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform
Yard Work:	☐ No Effect	☐ Mild Painful (Can do)	☐ Mod Painful (Limited)	☐ Sev Unable to Perform

Occupational Activities: (Check one that best describes your job description)

Administration ☐	Business Owner ☐	Clerical/Secretary ☐	Computer User ☐
Heavy Equipment operator ☐	Daycare/Childcare ☐	Construction ☐	Health Care ☐
Food Service Industry ☐	Medium Manual Labor ☐	Manufacturing ☐	Home Services ☐
Heavy Manual Labor ☐	Light Manual Labor ☐	Executive/Legal ☐	Housekeeper ☐
Other _____			

Condition's Effect On Job Performance: ☐ No Effect ☐ Mild (painful can do) ☐ Moderate (painful limited ability)
☐ Moderate/Sever (limited duty) ☐ Sever (can not work)

Recreational Activity:

Exercise Routine: None ☐ Moderate (2 – 3 days per week) ☐ Daily ☐ Heavy ☐

Effects of Current Condition on Performance: ☐ No Effect ☐ Mild Painful (Can do) ☐ Mod/Painful (limited)
☐ Sever/Unable to Perform

Do you have children? Yes / No If Yes, please list ages and gender: _____

Patient Name _____

Date _____

Height: _____ Weight: _____

Name of Primary Care Physician: _____ Date Last Exam _____

Address/Location: _____

What treatment(s)/medical attention have you already received for your present condition:

Medications ☐ Surgery ☐ Physical therapy ☐ Chiropractic Services ☐ Specialist(s) ☐ None ☐

Other: _____

Have you had any imaging for this condition/problem (X-Rays, MRI, CT, ect.) _____

Have you been to a chiropractor in the last 3 years? ☐ Yes / No ☐

Past Surgeries and/or injuries:

Date/Age: _____	Illness/Injury	Hospitalization	Surgery (explain) _____
	Still have problems	Still suffer occasionally from problem	Complete recovery
Date/Age: _____	Illness/Injury	Hospitalization	Surgery (explain) _____
	Still have problems	Still suffer occasionally from problem	Complete recovery
Date/Age: _____	Illness/Injury	Hospitalization	Surgery (explain) _____
	Still have problems	Still suffer occasionally from problem	Complete recovery

Social History: (Check all that apply to you)

Caffeine use:	occasional ☐	often ☐	never ☐	former user ☐
Drink Alcohol:	occasional ☐	often ☐	never ☐	former user ☐
Exercise:	occasional ☐	often ☐	never ☐	
Chew Tobacco:	occasional ☐	often ☐	never ☐	former user ☐
Cigarettes:	<1 pack/day ☐	>1 pack/day ☐	never ☐	former smoker ☐
Wear Seat Belts:	occasional ☐	always ☐	never ☐	
Other _____				

Family History: (Check all that apply)

Arthritis:	Parent ☐	Sibling ☐
Cancer:	Parent ☐	Sibling ☐
Diabetes:	Parent ☐	Sibling ☐
Heart Disease	Parent ☐	Sibling ☐
Hypertension	Parent ☐	Sibling ☐
Stroke	Parent ☐	Sibling ☐
Thyroid	Parent ☐	Sibling ☐
Other _____		

Patient Name _____ Date _____

Review of Systems –(Write in box Y if you have had trouble with any of the following, Write N if none)

Cardiovascular	Past	Present	No	Respiratory	Past	Present	No	Allergic/Immunologic	Past	Present	No
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								Ear, Nose and Throat			No
Jaw Pain				Eyes			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				Psychiatric			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				Gastrointestinal			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				Hematologic			No				
Pinched Nerves					Past	Present		Musculoskeletal			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											
Difficulty Sleeping											
Are you pregnant											

Patient Name

Date

(7.31.2015)

MEDICATION – VITAMIN – ALLERGY LIST

Do you take any medications or vitamins? YES ☐/ NO ☐

If YES, please list below:

Medication name	Dosage (i.e. 5mg)	Frequency (i.e. 1 tablet/ day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any ALLERGIES to medication? YES ☐/ NO ☐

If YES, please list medication name and place the given number next to the associated adverse reaction.

Medication(s)	Adverse Reaction(s)
(#1) _____	Anemia or Blood Disorders _____
(#2) _____	Asthma or Shortness of Breath _____
(#3) _____	Nausea, Vomiting, Diarrhea or GI distress _____
(#4) _____	Induced Shock or Unconsciousness _____
(#5) _____	Skin, Rashes or Hives _____
	Other, please describe _____

Patient Signature: _____

Date _____

(7.31.2015)