

# PATIENT REGISTRATION

Date\_\_\_\_\_

Last Name\_\_\_\_\_ First Name\_\_\_\_\_ MI\_\_\_\_\_

Street Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip Code\_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email Address\_\_\_\_\_

Home Phone(\_\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_\_) \_\_\_\_\_

Sex  Male  Female Date of Birth\_\_\_\_\_ Age\_\_\_\_\_

Marital Status  Married  Single  Divorced  Widowed  Partnered  Minor

Patient Employer/School\_\_\_\_\_

Occupation\_\_\_\_\_ Employer Phone(\_\_\_\_\_) \_\_\_\_\_

Employer/School Address\_\_\_\_\_

Spouse's Name\_\_\_\_\_

Spouse's Employer\_\_\_\_\_

Whom may we thank for referring you?\_\_\_\_\_

In Case Of Emergency, Contact:

Name\_\_\_\_\_ Relationship\_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_\_) \_\_\_\_\_

Are any of your family members or friends in need of chiropractic care?  Yes  No



Ortega Chiropractic Corp.- 5539 Roosevelt Boulevard- Jacksonville, FL 32244

(904) 425-4545

## HEALTH HISTORY

**What treatment have you already received for your condition?**    Medication    Surgery  
 Physical Therapy    Chiropractic    None    Other \_\_\_\_\_

**Name of other doctor(s) who you have seen for this condition** \_\_\_\_\_

**Date of Last:**

Physical Exam \_\_\_\_\_   X-ray \_\_\_\_\_   MRI/CT \_\_\_\_\_

**Please Circle if you have had any of the following:**

AIDS/HIV	Chicken Pox	Liver Disease	Rheumatoid Arthritis
Alcoholism	Diabetes	Measles	Rheumatic Fever
Allergies	Emphysema	Migraines	Scarlet Fever
Anemia	Epilepsy	Miscarriage	Stroke
Anorexia	Fractures	Multiple Sclerosis	Suicide Attempt
Appendicitis	Glaucoma	Mumps	Thyroid Problems
Arthritis	Goiter	Osteoporosis	Tonsillitis
Asthma	Gout	Pacemaker	Tuberculosis
Bleeding Disorders	Heart Disease	Parkinson's	Tumors, Growths
Breast Lump	Hepatitis	Pinched Nerve	Typhoid Fever
Bronchitis	Hernia	Pneumonia	Ulcers
Bulimia	Herniated Disc	Polio	Vaginal Infections
Cancer	Herpes	Prostate Problem	Venereal Disease
Cataracts	High Cholesterol	Prosthesis	Whooping Cough
Chemical Dependency	Kidney Disease	Psychiatric Care	Other

**Exercise:**    None    Moderate    Daily    Heavy

**Work Activity:**    Sitting    Standing    Light    Heavy

**Habits:**    Smoking    Alcohol    Coffee/Caffeine

**List Surgeries and Dates** \_\_\_\_\_

**Medications** \_\_\_\_\_

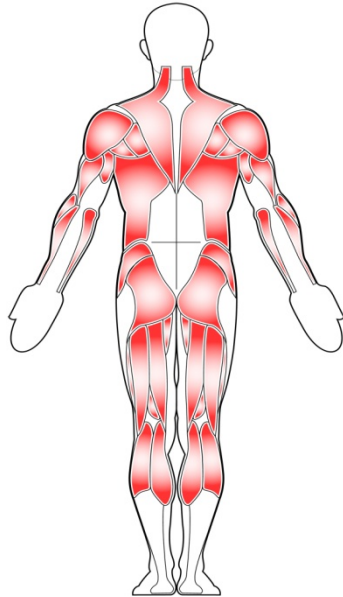
Name: \_\_\_\_\_

Date: \_\_\_\_\_

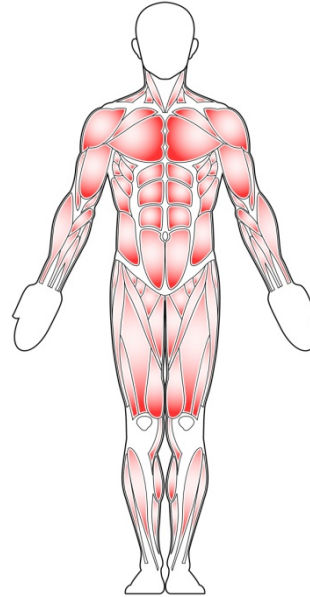
## Pain Evaluation

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Please mark an "x" on the picture where you have pain, numbness, or tingling.



Left      Back      Right



Right      Front      Left

When did your symptoms first appear? \_\_\_\_\_

Is this condition getting progressively worse?     Yes     No

Type of Pain:     Sharp     Dull     Burning     Shooting     Stiffness     Aching  
 Tingling     Cramping     Numbness     Swelling     Other

Is this pain constant?     Yes     No

How does this condition impact your.....

a) Home Life \_\_\_\_\_

b) Work Life \_\_\_\_\_

c) Social Life \_\_\_\_\_

Rate your commitment to fix this problem on a scale of 1(none ) to 10(total) \_\_\_\_\_