HAWKINS CHIROPRACTIC: CONFIDENTIAL REGISTRATION AND HISTORY FORM **TODAY'S DATE:** _____

Please allow our Team to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Patient's Name: _____
Permanent Street Address _____
City _____ State _____ Zip _____
MAILING Address _____
City _____ State _____ Zip _____
Permanent Phone # (____) _____
Cellular Phone# (____) _____ **Carrier** _____
Fax # (____) _____
E-mail Address _____
May we: TEXT you? ***Initials*** ____ E-mail you? ***Initials*** _____
Sex: ❍ Male ❍ Female DOB: __/__/____ Age: _____
❍Single ❍Married ❍Widowed ❍Separated ❍Divorced
Patient SS# ____ - ____ - ____
Number of Children _____ Race _____
Occupation (or **Retired from Occup.**) _____
Employer _____
Employer Address _____
_____
Employer Phone #(____) _____ Ext. _____
May we call you at work? ❍Yes ❍ No ***Initials*** _____
Describe your work environment: _____
Highest Level of Education _____
Spouse's Name _____
Date of Birth __/__/__ SS# ____ - ____ - ____
Occupation _____
Spouse's Employer _____
Person responsible for this account _____

MEDICAL CARE

Date of Last Physical: _____
Primary Care Physician (PCP) _____

How did you hear about our office? _____
Whom may we thank for referring you? _____

Have you ever received chiropractic care? ❍Yes ❍ No
How long ago? _____ With who? _____
City/State _____
Phone (____) _____
Were you satisfied with the care you received? ❍Yes ❍ No
How could it have been better? _____
_____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____
Home # (____) _____ Work # (____) _____

VISITORS ONLY: VISITOR INFORMATION

Where are you staying? _____
Address _____
Phone # (____) _____

ACCIDENT INFORMATION

Is this condition due to an accident? ❍Yes ❍ No
Date of Injury: _____
Type of Accident ❍Auto ❍Work ❍Home ❍Other
To who have you made a report of your accident?
❍Auto Insurance ❍Employer ❍Work Comp ❍Other
Attorney Name _____
Assistants Name _____
Address _____
_____
Phone # (____) _____ Fax # (____) _____
Work Injuries: Supervisors (HR) Name _____
Phone # (____) _____ Fax # (____) _____

DOCTORS NOTES: _____
_____

Reviewing Doctor Init. _____ *Date* _____

HEALTH / SOCIAL HISTORY FOR_____ **TODAY'S DATE:** _____

Please list any **medications – amounts and intake instructions** - you are taking: _____

_____

Allergies/Medicines, etc:_____**:Vitamins/Herbs**:_____

Injuries/Surgeries you have had. *Please give description and approximate date.*

Motor Vehicle Accidents:_____

Any Falls _____

Head Injuries_____

Broken Bones_____

Dislocations_____

Surgeries_____

Other Serious Injuries _____

Immediate Family's Health History *(Children / Parents / Grand Parent- Paternal/Maternal):*_____

_____

WOMEN: Date of last menstrual period __/__/__ Are you pregnant? _____ Nursing? *Y / N*

Medical Conditions not Currently Expressed on the Patient Symptoms Form

❍ Heart Attack/Stroke	❍ Arthritis	❍ Ringing in the Ears	❍ Colitis
❍ Congenital Heart Defect	❍ Frequent Neck Pain	❍ Severe/Frequent Headaches	❍ Ulcer
❍ Other Heart Condition	❍ Jaw Pain	❍ Diabetes	❍ Gout
❍ Fainting/Seizures/Epilepsy	❍ Wrist Pain	❍ Dizziness	❍ Numbness-where?
❍ Shingles	❍ Shoulder Pain	❍ Emphysema / COPD	_____
❍ Psychiatric Problems	❍ Arm Pain	❍ Kidney Problems	❍ Tingling-where?
❍ Difficulty Breathing	❍ Leg Pain	❍ Artificial Bones/Joints	_____
❍ Hepatitis _____	❍ Lower Back Problems	❍ Cancer_____	❍ Muscle Spasms-where?
❍ Anemia	❍ Severe Frequent Earaches	❍ HIV Positive, AIDS	_____
❍ High Blood Pressure	❍ Glaucoma	❍ Tuberculosis	❍ Herniated Disc
❍ Alcohol/Drug Abuse	❍ Polio	❍ Rheumatoid Arthritis	❍ Osteoporosis
❍ High Cholesterol	❍ Asthma	❍ Prostate	

❍ Other Health Conditions:_____

Personal Habits

	Heavy	Moderate	Light	None	
Alcohol	❍	❍	❍	❍	____ drinks per: week/day/mo.: Wine/ Beer /Liquor
Caffeine	❍	❍	❍	❍	____ cups per day/week/mo: Coffee / Sodas
Tobacco	❍	❍	❍	❍	____ packs per day
Drugs	❍	❍	❍	❍	_____
Non-job Exercise	❍	❍	❍	❍	
Sleep	❍	❍	❍	❍	Side / Back / Stomach
Appetite	❍	❍	❍	❍	
Water Intake	❍	❍	❍	❍	____ cups per day
Stress Level	❍	❍	❍	❍	Reason:_____

Age of Mattress_____ or **Waterbed**_____ **Is your bed comfortable?** Yes / No

What kind of pillow do you use? ❍Thick ❍Medium ❍Thin ❍None ❍Support (Cervical Pillow)

Feet: Do you wear? ❍Heel Lifts ❍Shoe Lifts ❍Arch Supports ❍Orthotics ❍None

******IMPORTANT**** As a result of my chiropractic care I would like to (check all that apply):** ❍ *Feel Better Quickly* ❍ *Have a healthier spine* ❍ *Have a healthier body by keeping my nervous system healthy* ❍ *Live a healthier lifestyle.*

DOCTORS NOTES: _____

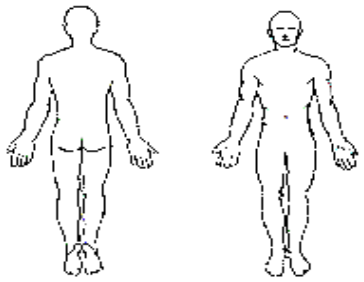
_____

*Reviewing Doctor Init.*_____ *Date*_____

HEALTH / SOCIAL HISTORY FOR_____ **TODAY'S DATE:** _____

#1 Symptom Pain: Neck / Low Back/ SI Joint / Mid Back / Headache_____

Mark Area of Discomfort on Drawing



Date of onset of symptom? _____

Did anything **contribute** to the **onset** of your condition: _____

_____

Is this condition getting **progressively worse**? Yes / No / Unknown

Is your **condition worse in** the: A.M. / P.M. / All the Time / Doesn't Apply _____

Interferes with Work / Sleep / Daily Routine / Recreation _____

Describe your Discomfort: Sharp when Moving / Sharp when NOT Moving / Dull / Throbbing / Aching / Shooting / Numbness / Burning / Tingling / Cramping / Stiffness / Swelling / Other:_____

_____

Does your discomfort **radiate or travel** (ex. from the neck to the shoulder)? If so, where:_____

Rate the severity of your discomfort (1 = minimal discomfort and 10 = severe pain) **Now** _____ **At its worst** _____

What **percentage of the time** do you feel your discomfort? 0-25% / 26-50% / 51-75% / 76-100%

Activities or movements that are painful/aggravate condition: Sitting / Standing / Walking / Bending / Lying Down / Everything

Other:_____

What activities /movements/medications make your **condition feel better**? Nothing / Other:_____

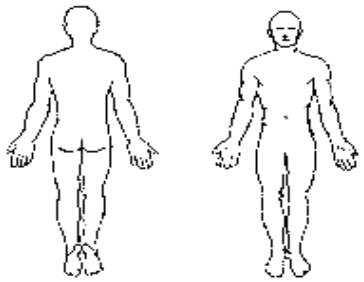
_____

Have you had this **EXACT same condition** before? Yes / No. If so, when: _____

Other Physicians, DC's, or Therapists seen for condition: _____

#2 Symptom (Pain) : Neck / Low Back/ SI Joint / Mid Back / Headache_____

Mark Area of Discomfort on Drawing



Date of onset of symptom? _____

Did anything **contribute** to the **onset** of your condition: _____

_____

Is this condition getting **progressively worse**? Yes / No / Unknown

Is your **condition worse in** the: A.M. / P.M. / All the Time / Doesn't Apply _____

Interferes with Work / Sleep / Daily Routine / Recreation _____

Describe your Discomfort: Sharp when Moving / Sharp when NOT Moving / Dull / Throbbing / Aching / Shooting / Numbness / Burning / Tingling / Cramping / Stiffness / Swelling / Other:_____

_____

Does your discomfort **radiate or travel** (ex. from the neck to the shoulder)? If so, where:_____

Rate the severity of your discomfort (1 = minimal discomfort and 10 = severe pain) **Now** _____ **At its worst** _____

What **percentage of the time** do you feel your discomfort? 0-25% / 26-50% / 51-75% / 76-100%

Activities or movements that are painful/aggravate condition: Sitting / Standing / Walking / Bending / Lying Down / Everything

Other:_____

What activities /movements/medications make your **condition feel better**? Nothing / Other:_____

_____

Have you had this **EXACT same condition** before? Yes / No. If so, when: _____

Other Physicians, DC's, or Therapists seen for condition: _____

Doctors Notes: _____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Hawkins or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that no guarantee or warranty has been made to me that results will be to my complete satisfaction.

Patient/Guardian Signature_____ ***Date***_____

*Reviewing Doctor Signature*_____ *Date*_____