REGISTRATION

Date

Denholm Family Chiropractic

PATIENT INFORMATION

Name _____ Home Phone: _____

Address _____ Cell Phone: _____

City _____ ST _____ Zip _____ Preferred Language: _____

Mailing Address: _____ Race: _____ Ethnicity: _____

Date of Birth : _____/_____/_____ *Smoking Status*: □ Presently □ Past □ Never

□ Single □ Married □ Divorced □ Widowed *Height:* _____ft _____in *Weight*: _____ lbs.

Social Security # xxx / xx / _____ Driver's License # _____ *Sex* : □ M □ F

E-Mail Address _____

Children: how many _____ Ages: _____

Employer _____ Occupation: _____

Work Phone: _____ - _____- _____ May we contact you at work? □ Y □ N

Primary Care Physician: _____ City: _____

Spouse's Name _____ *Date of Birth* _____ *Phone:* _____

Whom may we thank for referring you?

_____

With whom may we share your Protected Health Information?

_____

_____

PCP: _____

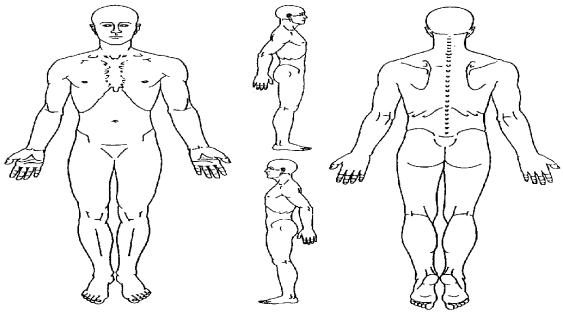
Denholm Family Chiropractic

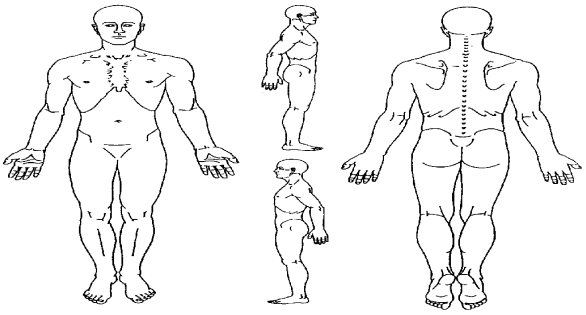
Patient Health Questionnaire

Patient Name: _____ Date: _____

ST – Stiffness **TG –** Tightness **D –** Dull **C -** Continuous **A-** Ache **SM -** Spasms

SH – Shooting **N-** Numbness **SP-** Sharp **B-** Burning **T-** Tingling **TH-** Throbbing





1st Complaint _____

When did it start? _____

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

How are your symptoms changing?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

What makes your symptoms worse?

_____

What makes your symptoms better?

_____

When is it the worse? ☐ Morning

☐ Afternoon ☐ Evening ☐ Just before bed

Have you received treatment for this symptom?

If so, what? _____

Have you had similar symptoms in the past?

If so, when? _____

2nd t Complaint _____

When did it start? _____

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

How are your symptoms changing?

☐ Getting Better ☐Not Changing ☐ Getting Worse

What makes your symptoms worse?

_____

What makes your symptoms better?

_____

When is it the worse? ☐ Morning

☐ Afternoon ☐ Evening ☐ Just before bed

Have you received treatment for this symptom?

If so, what? _____

Have you had similar symptoms in the past?

If so, when? _____

Additional Symptoms _____

What do you hope to get from your visit / treatment ? (select all that apply)

☐ Reduce symptoms ☐ Explanation of condition / treatment ☐ Resume / increase activity

☐ Learn how to take care of this on my own ☐ How to prevent this from occurring again

MUSCULO-SKELETAL

Past Present

___ ___ Neck pain
___ ___ Ear pain
___ ___ Jaw pain
___ ___ Throat pain
___ ___ Shoulder pain L. R.
___ ___ Arm pain L. R.
___ ___ Elbow pain L. R.
___ ___ Wrist pain L. R.
___ ___ Hand pain L. R.
___ ___ Pain between the shoulders
___ ___ Mid / upper back pain
___ ___ Chest pain L. R.
___ ___ Stomach pain L. R.
___ ___ Low back pain
___ ___ Buttock pain
___ ___ Hip Pain L. R.
___ ___ Leg pain L. R.
___ ___ Knee pain L. R.
___ ___ Ankle pain L. R.
___ ___ Foot pain L. R.
___ ___ Toe pain L. R.
___ ___ Muscle spasms

FEMALES ONLY

___ ___ Hot Flashes
___ ___ Birth Control Pills
___ ___ Pregnant

GASTRO-INTESTINAL

Past Present

___ ___ Bloating
___ ___ Constipation
___ ___ Diarrhea
___ ___ Heartburn
___ ___ Hemorrhoids
___ ___ Nausea
___ ___ Stomach pain
___ ___ Ulcers
___ ___ Vomiting
___ ___ Gall Bladder
___ ___ Irritable Bowel Syndrome

GENITO-URINARY

Past Present

___ ___ Bladder Infection
___ ___ Blood in Urine
___ ___ Kidney Disorder
___ ___ Lack of Bladder control
___ ___ Painful Urination
___ ___ Prostate Problems

CARDIO-VASCULAR

Past Present

___ ___ Chest Pain
___ ___ Heart Attack
___ ___ High Blood Pressure
___ ___ Low Blood Pressure
___ ___ Irregular Heart Beat
___ ___ Poor Circulation
___ ___ Stroke
___ ___ Varicose Veins

GENERAL

Past Present

___ ___ Arthritis
___ ___ Alcohol Dependency
___ ___ Asthma
___ ___ Cancer
___ ___ Depression
___ ___ Diabetes
___ ___ Dizziness
___ ___ Drug Dependency
___ ___ Epilepsy
___ ___ Fainting
___ ___ Fatigue
___ ___ Forgetfulness
___ ___ Frequent Colds/Flu
___ ___ Headache
___ ___ Hepatitis
___ ___ HIV / Aids
___ ___ Irritable
___ ___ Loss of Balance
___ ___ Loss of Sleep
___ ___ Loss of Appetite
___ ___ Lupus
___ ___ Migraines
___ ___ Nervousness
___ ___ Rheumatoid Arthritis
___ ___ Stress
___ ___ Stutter
___ ___ Ringing in ears
___ ___ Sinus allergies
___ ___ Shortness of Breath
___ ___ C-Pap

Other: _____

INDICATE IF AN IMMEDIATE FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING:

___Rheumatoid Arthritis ___Heart Problems ___Diabetes ___Cancer ___Lupus ___High/Low Blood Pressure

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

Name	Dosage	Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pharmacy: _____ ***Location:*** _____

List all **Drug Allergies*:*** _____ _____ _____

List all **Surgical Procedures*:*** _____ _____ _____

_____ _____ _____ _____

PATIENT SIGNATURE: _____ ***DATE:*** _____