Neighborhood Chiropractic and Acupuncture LLC
Registration and History

PATIENT INFORMATION

Last Name:	Date:
First Name	Middle Initial:
Address:	
City:	State: Zip:
Cell Phone Number:	Home Phone Number:
Email:	May we send you e-mail correspondence? ○Yes ○No
Sex: ○M ○F	Pronoun Preference: ○He ○She ○They ○Ze ○
○ Single ○Married ○Domestic Partnership ○Divorced ○Widowed ○Minor	
Birthdate:	Age:
Occupation:	
Patient Employer and/or School:	
Work Phone Number:	May we call you at work? ○Yes ○No
Who is responsible for this account? ○Self ○Insurance Company ○Guardian Name:	
Who do we thank for referring you?	

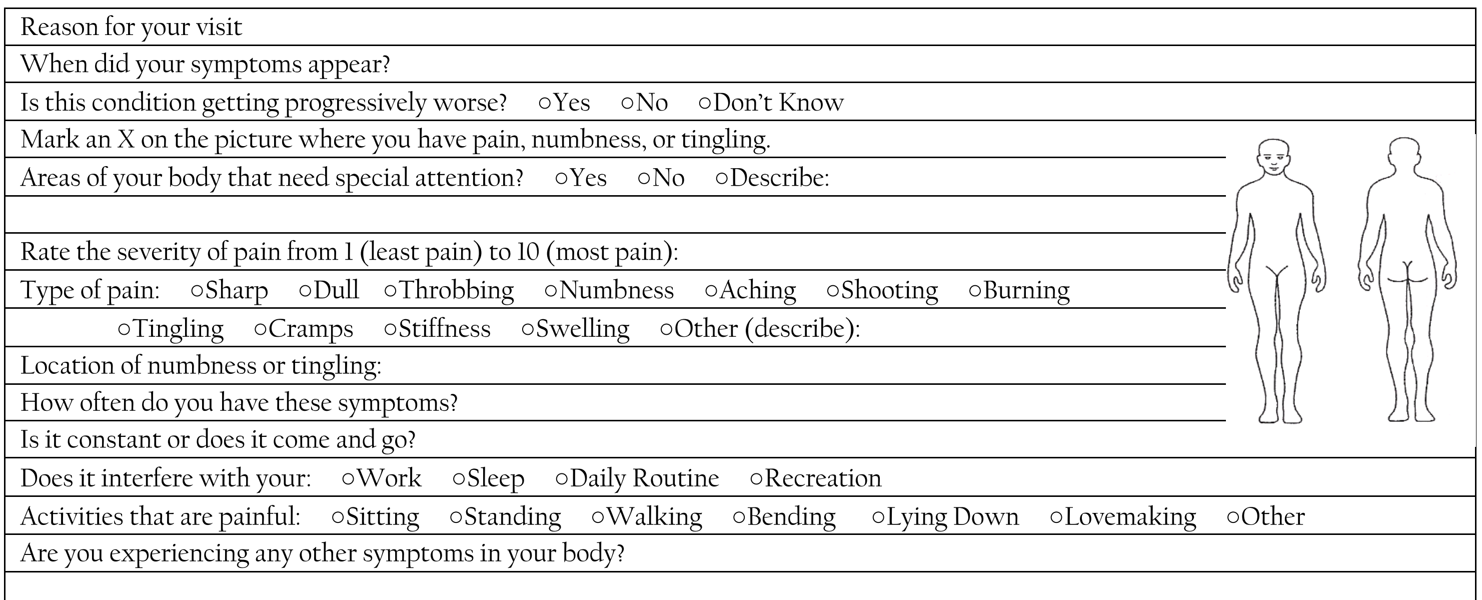
In Case of Emergency, Contact

Name:	Relationship:
Home Phone:	Work Phone:
Primary Care Physician:	Phone Number:

ACCIDENT INFORMATION

Is this condition due to an accident? ○Yes ○No	Date of Accident:
Type of Accident: ○Auto ○Work ○Home ○Other:	
To whom have you made report of your accident? ○Auto Insurance:	
○Employer ○Worker Comp. ○Other:	
Claim # (if applicable):	Attorney Name (if applicable):

PATIENT CONDITION



Reason for your visit
When did your symptoms appear?
Is this condition getting progressively worse? ○Yes ○No ○Don't Know
Mark an X on the picture where you have pain, numbness, or tingling.
Areas of your body that need special attention? ○Yes ○No ○Describe:
Rate the severity of pain from 1 (least pain) to 10 (most pain):
Type of pain: ○Sharp ○Dull ○Throbbing ○Numbness ○Aching ○Shooting ○Burning
○Tingling ○Cramps ○Stiffness ○Swelling ○Other (describe):
Location of numbness or tingling:
How often do you have these symptoms?
Is it constant or does it come and go?
Does it interfere with your: ○Work ○Sleep ○Daily Routine ○Recreation
Activities that are painful: ○Sitting ○Standing ○Walking ○Bending ○Lying Down ○Lovemaking ○Other
Are you experiencing any other symptoms in your body?

HEALTH HISTORY

What treatment have you already had for your condition? ○Medications ○Surgery ○ Physical Therapy ○Chiropractic Services ○None ○Other:

Name of other practitioners who have treated you for this condition:

Have you ever had chiropractic care? ○Yes ○No Massage? ○Yes ○No Acupuncture? ○Yes ○No

Date of Last: Physical Exam: X-ray (Area): Lab Work:

Spinal Exam: MRI, CT-Scan or Bone Scan:

Place a mark in the box to indicate if you have had any of the following:

- ○ AIDS/HIV
- ○ Allergies to oils/ fragrance
- ○ Anemia
- ○ Arm/ Hand Pain
- ○ Arthritis
- ○ Asthma
- ○ Bleeding Disorders
- ○ Blood clots
- ○ Cancer
- ○ Cataracts
- ○ Chemical Dependency
- ○ Chicken Pox
- ○ Communicable disease
- ○ Contacts
- ○ Diabetes
- ○ Dizziness
- ○ Eating Disorder
- ○ Easy Bruising
- ○ Emphysema
- ○ Epilepsy/ seizures
- ○ Fainting
- ○ Fibroids
- ○ Fibromyalgia
- ○ Glaucoma
- ○ Gonorrhea
- ○ Headaches
- ○ Hearing Difficulty
- ○ Heart Disease
- ○ Hepatitis
- ○ Herniated Disc
- ○ Hernia
- ○ High Cholesterol
- ○ Jaw Problems
- ○ Kidney Disease
- ○ Leg/Foot Disease
- ○ Liver Disease
- ○ Low Back Problems
- ○ Low Blood Pressure
- ○ Multiple Sclerosis
- ○ Neck Pain/ Stiffness
- ○ Open cuts or sore
- ○ Osteoporosis
- ○ Pacemaker
- ○ Parkinson's disease
- ○ Pinched Nerve
- ○ Pneumonia
- ○ Polio
- ○ Prosthesis
- ○ Psychiatric Care
- ○ Respiratory Problems
- ○ Rheumatoid Arthritis
- ○ Rheumatic Fever
- ○ Sciatica
- ○ Shoulder Problems
- ○ Skin Disease
- ○ Stroke
- ○ Thyroid Problems
- ○ Transient Ischemic Attack (TIA)
- ○ Tuberculosis
- ○ Tumors/ Growths
- ○ Typhoid
- ○ Ulcers
- ○ Varicose Veins
- ○ Venereal Disease

□Other condition not listed above:

Exercise: ○None ○Moderate ○Daily ○Heavy Describe:

Work Activity: ○Sitting ○Standing ○Light Labor ○Heavy Labor

Habits: ○Smoking: # Cigarettes or Packs/day? ____ How many years? ___ Were you ever a smoker? ○Yes ○No
○Alcohol: # Drinks/week? ____ ○Caffeine Drinks # Cups/Day? ____ ○High Stress Level Reason:

Women: Are you pregnant? ○Yes ○No Due Date: Number of children:

Injuries/ Surgeries (Include a date and a description):

Falls:

Head Injuries:

Broken Bones:

Dislocations:

Surgeries:

Car Accidents:

Family Health History

Has anyone in your immediate family had the following conditions? (including grandparents):
○Heart Disease ○Stroke ○Cancer ○Diabetes ○Other Describe any selected:
○Other Family Diseases:

Medications: For what condition?

Vitamins/Herbs/Supplements:

Allergies:

Is there anything else you would like to share with your doctor?

To the best of my knowledge, this information is complete and correct. I understand it is my responsibility to inform my doctor/Clinic if there are any changes to my health or personal information.

Signature Printed Name Date

Neighborhood Chiropractic and Acupuncture LLC
Acupuncture Health History

Name: ____ Date: ____/____/____
(first) (middle) (last)

Date of Birth: ____/____/____ Age: ________ Gender: M/F/X/_____ Pronoun:______ Marital status: S M DP D W

Successful health care and preventive medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? ____

For what reason? ____

2. Please identify the health concerns that have brought you in order of importance below:

Condition	Past Treatment
a. ______________________	______________________
How does this condition affect you?	______________________
b. ______________________	______________________
How does this condition affect you?	______________________
c. ______________________	______________________
How does this condition affect you?	______________________
d. ______________________	______________________
How does this condition affect you?	______________________

3. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

____

____

4. Please list any medications (prescribed and over-the-counter), vitamins, herbs, and supplements you are currently taking:

____

____

____

5. Do you have any reason to believe you may be pregnant? ○ No ○ Yes, how far along? ______________________

6. Do you have any infectious diseases? ○ No ○ Yes, please identify: ______________________

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7. **Family History:**
Check those applicable:

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	______	______	______	______	______	______
Health (G=Good, P=Poor)	______	______	______	______	______	______
Cancer	______	______	______	______	______	______
Diabetes	______	______	______	______	______	______
Heart Disease	______	______	______	______	______	______
High Blood Pressure	______	______	______	______	______	______
Stroke	______	______	______	______	______	______
Mental Illness	______	______	______	______	______	______
Asthma/Hay fever/Hives	______	______	______	______	______	______
Kidney Disease	______	______	______	______	______	______
Age (at death)	______	______	______	______	______	______
Cause of Death	______	______	______	______	______	______

8. **Height:** _______________ **Weight:** Currently: ______________ Past Maximum: ____________ When? ________________

9. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _______________

10. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

11. **Immunizations** (please circle any that you have had, or had reactions to):

PolioTetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: ____

12. **Hospitalizations and Surgeries:**

Reason	When	Reason	When

13. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When

14. **Emotional/Mental** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Poor Concentration Memory Problems Seasonal Depression

15. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome Chronic Swollen Glands

16. **Head, Eye, Ear, Nose, & Throat** (Please circle any that you experience now. Underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness Dizziness

Impaired Hearing Ear Ringing Stuffiness Loss of Smell Earaches Headaches/Migraines Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever Head Trauma

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17. **Respiratory** (Please circle any that you experience now. Underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema Persistent Cough Pleurisy
Bronchitis Asthma Tuberculosis Wheezing Shortness of Breath Other: ____________________

18. **Cardiovascular** (Please circle any that you experience now. Underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High/Low Blood Pressure Palpitations/Fluttering Stroke
Heart Murmurs Rheumatic Fever Varicose Veins

19. **Gastrointestinal** (Please circle any that you experience now. Underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Constipation Diarrhea Epigastric Pain Passing Gas
Heartburn Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

20. **Genito-Urinary Tract** (Please circle any that you experience now. Underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Kidney Stones Impaired Urination
Blood in Urine Frequent Urination at Night

22. **Female Reproductive/Breasts** (Please circle any that you experience now. Underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow Vaginal Discharge
Premenstrual Problems Clotting Bleeding Between Cycles Menopausal Symptoms Difficulty Conceiving
Painful Periods Pain with Intercourse

Date of last annual exam_______ Was it normal? ○ Yes ○ No Have you had an abnormal pap? ○ No ○ Yes, when?________

Have you been diagnosed with Ovarian Cysts, Endometriosis, PCOS, Fibroids, or any STD's? (please circle any that apply)

Do you do regular breast exams? ○ Yes ○ No

24. **Menstrual/Birthing History:**

a. Age of First/Last Menses: ______ d. Birth Control Type: _______ g. # of Abortions: _______
b. # of Days of Menses: _____ e. # of Pregnancies: _______ h. # of Live Births: _______
c. Length of Cycle: ______ f. # of Miscarriages: _______

25. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge Hernias STD's

26. **Musculoskeletal** (Please circle any that you experience now. Underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arthritis Arm Pain Upper Back Pain Mid Back Pain
Low Back Pain Leg Pain Joint Pain (if so, where?): ____________________

27. **Neurologic** (Please circle any that you experience now. Underline any that you have experienced in the past):

Vertigo/Dizziness ParalysisNumbness/Tingling Loss of Balance Seizures/Epilepsy

28. **Endocrine** (Please circle any that you experience now. Underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold Fatigue

29. **Other** (Please circle any that you experience now. Underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet Acne General Itchiness
Is there anything else we should know? ____________________

30. **Lifestyle: What does your typical diet consist of?** ____

____

a. Do you typically eat at least three meals per day? ○Yes ○No, how many? ____________

b. Exercise routine: ____

c. Spiritual practice: ____

d. How many hours per night do you sleep? ______ Do you wake rested? ○Yes ○ No

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: ____________________ Employer: ________________ Hours/Week: _____

Do you enjoy work? ○ Yes ○ No Why/Why not? ______________________________

g. Nicotine/Alcohol/Caffeine Use: ____

h. Have you experienced any major traumas? ○ No ○ Yes, explain: ______________________

____

i. How many glasses of water do you drink per day? ____

j. Do you take vacations? ○ Yes ○ No Do you spend time outdoors? ____________________

k. Do you eat refined sugar? _____ Do you add salt? _____ Do you eat out often? ______ Do you go on diets often? ______

l. Have you ever been treated for drug or alcohol addiction? ______________________________

m. Television habits: ____________________ Reading habits: ____________________

n. Do you have supportive relationships in your life? ______________________________

o. Interests and hobbies: ____

Neighborhood Chiropractic
and Acupuncture LLC

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HIPAA Policy – Acknowledge of Receipt of Notice of Privacy Practices

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practice of Neighborhood Chiropractic and Acupuncture which describes the Practice policies and procedures regarding the use and disclosure of any of my Protected Health information created, received, or maintain by the Practice.

Missed/Cancellation Policy

When you make an appointment, you're paying for the practitioner's time. Appointments require a 24-hour business day cancellation notice. For Saturday, Sunday, and Monday appointments, cancellation must occur prior to Friday at noon. **If we do not receive 24-hour business day notice, you will be charged a $25 appointment cancellation fee.** We are unable to bill insurance companies for missed appointments. Thank you for your understanding of this matter.

Communication Consent

We are adding different communication options to provide you with more personalized and integrative ways to inform you about your care. In order to communicate information regarding your care, account, appointments, and the clinic, we need permission to do so. We will never sell any of your information, nor use it for unsolicited marketing purposes.

By signing this, you authorize Neighborhood Chiropractic and/or our automated third-party reminder service to contact you and/or named authorized person(s) and to convey Personal Health Information by the following methods and assume responsibility to notify Neighborhood Chiropractic whenever this information changes.

Text Message: ___Yes Text: ________________________________
___No, provider may not contact me by text message.

Detailed Voicemail: ___Yes Phone: ________________________________
___No, Provider may only leave a name and phone number.

Detailed Email: ___Yes Email: ________________________________
___No, provider may not contact me by email.

Please list names & relationships of other people authorized to receive information about your care:

____

I hereby attest the above information is correct, and that I have read and understood the above policies.

Print Name: ______________________________________ Date: ____________________________

Signature: ______________________________________