



# New Patient Registration

700 Harkrider Conway, AR 72032 (501) 513-3322

Today's Date:     /     /

Whom can we thank for referring you? \_\_\_\_\_  Family  Friend  Sign  
 Co-Worker  Close to home/work  Doctor  Yellow pages  Drove by  Hospital  Insurance Plan

## Personal Information

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_ Sex: Male / Female

Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone :(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Best time to call: \_\_\_\_\_

Best number to use:  home  cell  other \_\_\_\_\_

Status:  Single  Married  Divorced  Widowed  Separated     Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_     Email Address: \_\_\_\_\_

Children (Names and Ages): \_\_\_\_\_

## Employment Information

Business Name: \_\_\_\_\_ Occupation/Job Title: \_\_\_\_\_

Business Address: \_\_\_\_\_ Business Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Type of Work (ex. manual labor, desk work, driving and etc.): \_\_\_\_\_

## Spouse's Information for Insurance Purposes

Spouse's Name: \_\_\_\_\_ Spouse's Social Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

## Emergency Contact

Name: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

Relationship:  Spouse  Relative  Friend  Other \_\_\_\_\_

Current Health Condition

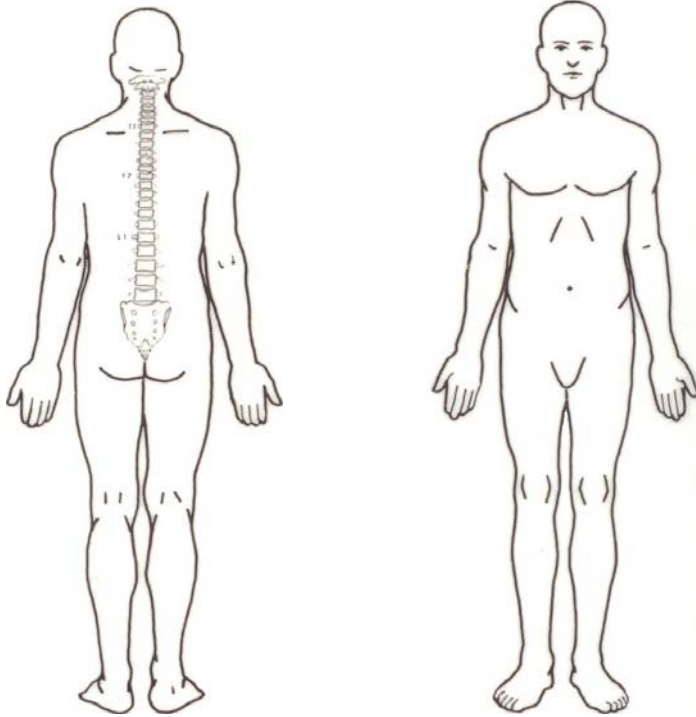
Primary Complaint(s) /Why you are here today? \_\_\_\_\_

Severity of Pain

List region of pain and circle severity number (1 = least, 10 = greatest)

MARK PAIN REGION EXAMPLE. \_\_\_\_\_ (sharp)

1 2 3 4 5 (6) 7 8 9 10



Regions:

Please mark areas(s) of pain on The drawing on the left.

Neck \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10

Mid Back \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10

Low Back \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10

Hips \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10

Arms \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10

Legs \_\_\_\_\_

1 2 3 4 5 6 7 8 9 10

Personal History

When did primary complaint BEGIN? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Has it ever occurred before?  Yes  No. When? \_\_\_\_\_

Is the Condition:  Auto Related  Job Related  Home Injury  
 Slip or Fall  Lifting  Slept Wrong  Unknown Cause  Other

Explain: \_\_\_\_\_

Have you seen other doctors for THIS CONDITION?  Yes  No

If yes, Who? (Name) \_\_\_\_\_

Type of Treatment: \_\_\_\_\_

Were you satisfied with the results of your treatment?  Yes  No

Explain: \_\_\_\_\_

List any broken bones or dislocations: \_\_\_\_\_

Have you ever been on crutches? \_\_Y \_\_N

Why? \_\_\_\_\_

Have you ever had a lapse of memory? \_\_Y \_\_N

Have you ever been unconscious? \_\_Y \_\_N

Have you had x-rays taken? \_\_Y \_\_N

When? \_\_\_\_\_ Where? \_\_\_\_\_

For what reason were these x-rays taken? \_\_\_\_\_

List any hospital stays within the last 2 years: \_\_\_\_\_

**Current Medication (s):** List ALL medications you are CURRENTLY taking. (Use back of page if needed)

**REVIEW OF SYSTEMS** -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

**Constitutional:**  I DENY having any of the symptoms or problems listed below.

- chills       daytime drowsiness       fatigue       fever       night sweats  
 weight gain       weight loss       other:

**Eyes/Vision:**  I DENY having any of the symptoms or problems listed below.

- blindness       blurred vision       cataracts       change in vision       double vision  
 eye pain       field cuts       glaucoma       itching       photophobia  
 tearing       glasses       contact lenses       other:

**Ears, Nose and Throat:**  I DENY having any of the symptoms or problems listed below.

- bleeding       dentures       difficulty swallowing       discharge       dizziness  
 ear drainage       ear pain       fainting       frequent sore throats       headaches  
 hearing loss       history of head injury       hoarseness       loss of sense of smell       nasal congestion  
 nosebleeds       postnasal drip       rhinorrhea (runny nose)       sinus infections       snoring  
 sore throat       tinnitus (ringing in ears)       TMJ problems       other:

**Respiration:**  I DENY having any of the symptoms or problems listed below.

- asthma       cough       coughing up blood       shortness of breath       sputum production  
 wheezing       other:

**Cardiovascular:**  I DENY having any of the symptoms or problems listed below.

- angina (chest pain or discomfort)       chest pain       claudication (leg pain/ache)  
 heart murmur       heart problems       high blood pressure  
 low blood pressure       orthopnea (difficulty breathing lying down)       palpitations  
 paroxysmal nocturnal dyspnea  
(waking at night w/ shortness of breath)       shortness of breath  
with exertion or exercise       swelling of legs  
 ulcers       varicose veins       other:

**Gastrointestinal:**  I DENY having any of the symptoms or problems listed below.

- abdominal pain       belching       black - tarry stools       constipation       diarrhea  
 difficulty swallowing       heartburn       hemorrhoids       indigestion       jaundice  
 nausea       rectal bleeding       abnormal stool       abnormal stool color       abnormal stool  
consistency  
 vomiting       vomiting blood       other:

**Female:**  I DENY having any of the symptoms/problems and/or using any of the items listed below.

- birth control       breast lumps/pain       burning urination       cramps       frequent urination  
 hormone therapy       irregular menstruation       pregnancy       urine retention       vaginal bleeding  
 vaginal discharge       other:

**Male:**  I DENY having any of the symptoms or problems listed below.

- burning urination       erectile dysfunction       frequent urination       hesitancy/  
dribbling       prostate problems  
 urine retention       other:

**Endocrine:**  I DENY having any of the symptoms or problems listed below.

- cold intolerance       diabetes       excessive appetite       excessive hunger       excessive thirst  
 abnormal frequency of urination       goiter       hair loss       heat intolerance       unusual hair grow  
 voice changes       other:

**Skin:**  I DENY having any of the symptoms or problems listed below.

- changes in nail texture       changes in skin color       hair growth       hair loss       hives
- history of skin disorders       itching       paresthesias       rash       skin lesions / ulcers
- varicosities       other:

**Nervous System:**  I DENY having any of the symptoms or problems listed below.

- dizziness       facial weakness       headache       limb weakness       loss of consciousness
- loss of memory       numbness       seizures       sleep disturbance       slurred speech
- stress       strokes       tremor       unsteadiness of gait       loss of balance
- other:

**Psychologic:**  I DENY having any of the symptoms or problems listed below.

- anhedonia       anxiety       loss or change in appetite       behavioral change       bi-polar disorder
- confusion       convulsions       depression       insomnia       memory loss
- mood change       other:

**Allergy:**  I DENY having any of the symptoms or problems listed below.

- anaphalaxis       food intolerance       itching       nasal congestion       rash
- sneezing       other:

**Hematologic:**  I DENY having any of the symptoms or problems listed below.

- anemia       bleeding       blood clotting       blood transfusion       bruising easily
- fatigue       lymph node swelling       other:

**PAST HEALTH HISTORY** – Fill out carefully as these problems can affect your overall course of care.

**Previous Chiropractic Care:**  I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: \_\_\_\_\_ Location: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_  
 Were you satisfied with your care?  Yes  No. Why? \_\_\_\_\_

**Adult Illness (es):** LIST all health conditions not previously specified. CIRCLE all CURRENT conditions.

\_\_\_\_\_  
 \_\_\_\_\_

**Surgery (ies):** LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

\_\_\_\_\_  
 \_\_\_\_\_

**Females ONLY:** Mark all that apply below.

I AM:  currently pregnant       NOT pregnant       unsure  
 Past Pregnancy History:  C-section # \_\_\_\_\_       vaginal delivery # \_\_\_\_\_       miscarriage # \_\_\_\_\_

**Injury (ies):** Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

- back injury       broken bones       fall (severe)       fracture
- disability (ies)       head injury       loss of consciousness       joint injury
- laceration (severe)       motor vehicle accident       soft tissue injury       other:

**Social History:** Mark all that apply below.

Tobacco:  Do not use Tobacco       Do not smoke cigars, cigarettes or pipe       Live with a smoker       Quit smoking  
 Smoke: # \_\_\_\_\_ per  Day  Week  Month;       Chew: # \_\_\_\_\_ cans per  Day  Week  Year

**Habits:** Mark all that apply below.

Alcohol # \_\_\_\_\_  Day  Week  Month;  Coffee # \_\_\_\_\_  Day  Week  Month  
 Soda # \_\_\_\_\_  Day  Week  Month  Exercise (type) # \_\_\_\_\_  Day  Week  Month