Vibrant Life Chiropractic

REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Patient's last name:	First:	Marital status:

Phone:	Email:	Birth Date:	Sex: M F

Address (Street, City, Postal code):

Name of Family MD.:	Phone:	Email:
Employer:	Employer Phone:	Email:
Name of Emergency Contact:	Phone:	Relationship:

How did you hear about us?

Other family members seen here:

HISTORY OF COMPLAINT

Please **WRITE DOWN** the conditions that brought you to this office and on a scale of **0-10** (10 being the worst pain) rate your above complaint by **circling** the number:

Primary:	0 – 1 – 2 – 3 – 4 – 5 - 6 - 7 – 8 – 9 - 10
Secondary:	0 – 1 – 2 – 3 – 4 – 5 - 6 - 7 – 8 – 9 - 10
Tertiary:	0 – 1 – 2 – 3 – 4 – 5 - 6 - 7 – 8 – 9 - 10

When did the primary problem begin?

When is the problem at its worst? AM or PM	How long does it last? Constant / On and off during the day / Comes and goes throughout the week

What relieves your symptoms?

What makes them feel worse?

How did the injury happen?

Condition(s) ever been treated by anyone in the past? Yes/No	If yes, when and by whom?
How long were you under care:	What were the results:
Have you ever been under Chiropractic care? Yes/No	If yes when was your last adjustment?

List Prescription & Non-Prescription drugs or supplements you take:

SOCIAL HISTORY

1. **Smoking**- cigars/pipe/cigarettes	Daily	Weekends	Occasionally	Never
2. Alcoholic Beverage	Daily	Weekends	Occasionally	Never
3. Recreational Drug use	Daily	Weekends	Occasionally	Never

HISTORY OF COMPLAINT

Identify **ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:

	How Long Ago	Type of Care Received	By Whom
Injuries			
Surgeries			
Adult Diseases			

SOCIAL HISTORY

4. **Smoking**- cigars/pipe/cigarettes	Daily	Weekends	Occasionally	Never
5. Alcoholic Beverage	Daily	Weekends	Occasionally	Never
6. Recreational Drug use	Daily	Weekends	Occasionally	Never

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? Yes / No
   If Yes whom:
   Any other hereditary conditions the doctor should be aware of? Yes / No
   If yes What?

INITIAL NERVE SYSTEM PROFILE

When was your last most recent auto accident?

Type of Impact:	Front Impact	Side Impact	Rear Impact

Was treatment received? Please Describe:

Please circle any of the following conditions that you are current suffering from:

Head Aches	Upper Back Pain	Low Back Pain
Allergies	Shoulder Pain	Neck Pain
Sinus Problems	Heart Problems	Menstrual Problems
Ear Infections	High/Low Blood Pressure	Menopausal Problems
TMJ	Heartburn	PMS
Dizziness/Vertigo	High Cholesterol	Prostate Problems
Loss of Balance/Fainting	Diabetes	Sexual Dysfunction/Impotence
Hearing Loss/Ringing in Ears	Numbness/Tingling	Infertility Problems
Double/Blurred Vision	Chest Pain	Spleen Problems
Anxiety/Depression	Breathing Difficulties/Asthma	Colon Problems
ADD/ADHD	Lung Problems	Bed Wetting
Learning Difficulties	Mid Back Pain	Hip Pain
Seizures/Tremors	Digestive Problems	Knee Pain
Stroke	Diarrhea/Constipation	Foot Pain
Irritable/Mood Changes	Gall Bladder Problems	Swollen/Painful Joints
Frequent Cold/Flu	Liver Problems	Scoliosis
Trouble Controlling Weight	Hepatitis (A / B / C)	Plantar Fasciitis
Trouble Sleeping	Kidney Problems	Are you Pregnant? Y / N

Other:

Patient Signature: ____________________________ Date: ____________