AMERICA'S CHIROPRACTIC CENTER

America's Chiropractic Center• 3916 Clarks Creek Rd • Plainfield, IN 46168
Phone: 317-271-2345 • Fax: 888-243-5128
www.AmericasChiropracticCenter.com

NEW PATIENT REGISTRATION

Name_____ Date of Birth ___/___/___Today's Date: ___/___/___
Last First M.I

Address_____
Street Apt# City State Zip

Cell Phone # (____) _____–_____ Home Phone # (____) _____–_____ May we Text you? ☐ Yes ☐ No

E-mail Address:_____ Employer _____Occupation_____

Marital Status: S M W D Name of Spouse: _____

Emergency Contact_____ Relationship_____ Phone# (____) _____–_____

How did you hear about our clinic?

☐ Website ☐ Location ☐ Internet Search ☐ Other _____

Friend referral: _____Physician referral: _____

Family Physician:_____ City/Phone:_____

Do we have permission to forward a copy of your evaluation to your medical physician? ☐ Yes ☐ No

Previous Chiropractor? ☐ Yes ☐ No

Dr._____ City/Phone_____ Date Last Seen: _____

CONSENT TO TREAT

To Our Patients:
Chiropractic examination and therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke and serious neurological impairment, injuries to the spinal discs, and spinal fractures. Serious complications are estimated to be in the range of .5 – 2 incidents per 5 million adjustments of the neck, and 1 per million for adjustments of the low back. Additional information on side-effects, complications and effectiveness of spinal adjustments is available upon request.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

_____
Patient signature Date

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PERSONAL HEALTH HISTORY

Patient Name:_____ Age: _____ Date: ____/____/_____

*List you complaint(s) **beginning** with the **most severe** and **ending** with the **least severe**:

Chief Complaint: _____ Symptoms began: _____

What caused your complaint? _____ Are your symptoms getting worse? ☐ Yes ☐ No

How often do you have this pain? ☐ Constant (76%-100%) ☐ Frequent (51%-75%) ☐ Occasional (26%-50%) ☐ Intermittent (25% or less)

Rate the severity of your pain on a scale from 0 (no pain) to 10 (worst pain imaginable) **Now**_____ **On average** _____ **Worst** _____

What makes your compliant **WORSE**? _____ **BETTER**? _____

Type of pain? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Burning ☐ Tingling ☐ Aching ☐ Shooting ☐ Stiffness ☐ Cramping

Do your symptoms radiate anywhere (i.e. into arms/legs)? _____ Have you had this before? ☐ Yes ☐ No

Activities that are difficult or painful to perform: ☐ Siting ☐ Standing ☐ Walking ☐ Bending ☐ Lying ☐ Sleeping

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2nd Complaint: _____ Symptoms began: _____

What caused your complaint? _____ Are your symptoms getting worse? ☐ Yes ☐ No

How often do you have this pain? ☐ Constant (76%-100%) ☐ Frequent (51%-75%) ☐ Occasional (26%-50%) ☐ Intermittent (25% or less)

Rate the severity of your pain on a scale from 0 (no pain) to 10 (worst pain imaginable) **Now**_____ **On average** _____ **Worst** _____

What makes your compliant **WORSE**? _____ **BETTER**? _____

Type of pain? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Burning ☐ Tingling ☐ Aching ☐ Shooting ☐ Stiffness ☐ Cramping

Do your symptoms radiate anywhere (i.e. into arms/legs)? _____ Have you had this before? ☐ Yes ☐ No

Activities that are difficult or painful to perform: ☐ Siting ☐ Standing ☐ Walking ☐ Bending ☐ Lying ☐ Sleeping

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3rd Complaint: _____ Symptoms began: _____

What caused your complaint? _____ Are your symptoms getting worse? ☐ Yes ☐ No

How often do you have this pain? ☐ Constant (76%-100%) ☐ Frequent (51%-75%) ☐ Occasional (26%-50%) ☐ Intermittent (25% or less)

Rate the severity of your pain on a scale from 0 (no pain) to 10 (worst pain imaginable) **Now**_____ **On average** _____ **Worst** _____

What makes your compliant **WORSE**? _____ **BETTER**? _____

Type of pain? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Burning ☐ Tingling ☐ Aching ☐ Shooting ☐ Stiffness ☐ Cramping

Do your symptoms radiate anywhere (i.e. into arms/legs)? _____ Have you had this before? ☐ Yes ☐ No

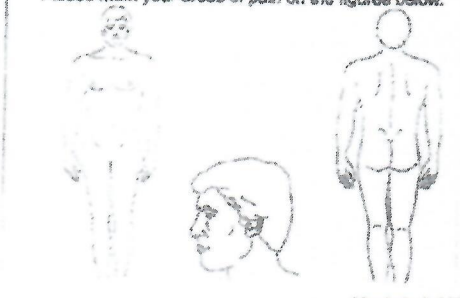
Activities that are difficult or painful to perform: ☐ Siting ☐ Standing ☐ Walking ☐ Bending ☐ Lying ☐ Sleeping

Pain Drawing

Circle and label the area on your body where you feel any of the described sensation(s)

Ache = A
Burning = B
Dull = D
Numbness = N
Pins & Needles (Tingling) = P
Sharp = Shp
Shooting – Sht
Soreness = So
Stabbing = St
Weakness = W

Please mark your areas of pain on the figures below.



Updated 4/19

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Patient Name _____ Date: _____/_____/_____

Please check the appropriate response. If you are not sure, check the "?" box.

Yes ( )	No ( )	? ( )	Do you have a history of cancer?
Yes ( )	No ( )	? ( )	Have you had any unexplained weight loss?
Yes ( )	No ( )	? ( )	Does your pain fail to improve with rest?
Yes ( )	No ( )	? ( )	Is your pain worse laying on your back or at night?
Yes ( )	No ( )	? ( )	Failure to respond to a course of conservative care (i.e. PT, acupuncture, steroids)?
Yes ( )	No ( )	? ( )	Have you had spinal pain greater than 4 weeks?
Yes ( )	No ( )	? ( )	Prolonged use of corticosteroids (such as organ transplant Rx)?
Yes ( )	No ( )	? ( )	Intravenous drug use?
Yes ( )	No ( )	? ( )	Current or recent urinary tract, respiratory tract, or other infection?
Yes ( )	No ( )	? ( )	Immunosuppression medication and/or condition?
Yes ( )	No ( )	? ( )	History of significant trauma?
Yes ( )	No ( )	? ( )	Minor trauma in person greater than 50 years old?
Yes ( )	No ( )	? ( )	Do you have osteoporosis (weak bones)?
Yes ( )	No ( )	? ( )	Are you over 70 years old?
Yes ( )	No ( )	? ( )	Any history of stroke/TIA (transient ischemic attack)?
Yes ( )	No ( )	? ( )	Acute onset urinary retention or overflow incontinence (wet underwear)?
Yes ( )	No ( )	? ( )	Loss of anal sphincter tone or rectal incontinence (bowel accidents)?
Yes ( )	No ( )	? ( )	Saddle anesthesia (numbness in the groin region)?
Yes ( )	No ( )	? ( )	Global or progressive muscle weakness in the legs (legs give out)?
Yes ( )	No ( )	? ( )	Do you have morning spinal stiffness greater than 1 hour?

Goals of Treatment

What are 3 things that this conditions is affecting (i.e. sitting, standing, work, playing with children, dishes, laundry, driving, etc.)?

1.

2.

3.

Patient signature Date

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Patient Name _____ **Date** _____/_____/_____

Current Medication – Please list name and dose (Include vitamins, herbal supplements, and over-the-counter medications.)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Past Medical History – List anything you have ever been diagnosed with including year which you were diagnosed.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Family Medical History – List any know conditions, current age, or age at death (please indicate cause of death)

Mother: _____

Father: _____

Siblings: _____

_____

Personal Habits – Please answer honestly. This information is needed to assure the best possible treatment. All information is confidential. Please rate your answer on a scale of 1 to 5, with 1 = No/Never and 5 = Yes/Often

	No/Never			Yes/Often		
	1	2	3	4	5	Elaborate
Exercise Regularly (3-4x/wk)						
Use Drugs						
Drink Alcohol						
Smoke						
Experience Stress						
Other						

Past History – Injuries

List all previous Fracture(s), Work Injuries, Surgeries, and Personal injuries (dates and residual effects if any)

1. Fractures: _____
2. Work injuries: _____
3. Surgeries: _____
4. Personal Injuries: _____