Swain
FAMILY CHIROPRACTIC

New Patient Adult Registration & History

Our Mission

To assist our patients in reaching their optimum health potential through Education, Truth, and Chiropractic care. To love, serve, give and teach.

Chiropractic Registration and History

Name:_____

Date of Birth:_____ Age:_____ Sex: M F

Address:_____

City:_____ State:_____ Zip:_____

Phone: H)_____ W)_____ C)_____Cell Carrier)_____

SSN:_____ Marital Status: S M D W # Children:_____

Occupation:_____

Driver's License#:_____ Email:_____

Is this the result of an auto accident: Y N Are you or have you been in the military? _____

Is this the result of a work-related injury? Y N Are you or is it possible you are pregnant? Y N

If yes, please indicate date:_____

Whom can we thank for referring you?_____

Please complete all information below that applies to your condition and fill in the spaces that describe your present complaint(s). Also, the information you provide concerning past symptoms will help in assisting the doctor to better understand your present complaints and total health picture.

Please list your present complaint(s) and mark your level of pain today for each complaint- If you have more than one area of complaint list them in order of most severe to least severe.

1. _____Duration – (How long/Date):_____ # of Previous Episodes: _____

(Please circle one) **(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (MOST PAINFUL)**

2. _____Duration – (How long/Date):_____ # of Previous Episodes: _____

(Please circle one) **(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (MOST PAINFUL)**

3. _____Duration – (How long/Date):_____ # of Previous Episodes: _____

(Please circle one) **(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (MOST PAINFUL)**

Emotional Complaint(s):

1. _____Duration – (How long/Date):_____ # of Previous Episodes: _____

(Please circle one) (NOT DEBILITATING) **0 1 2 3 4 5 6 7 8 9 10** (MOST DEBILITATING)

2. _____Duration – (How long/Date):_____ # of Previous Episodes: _____

(Please circle one) (NOT DEBILITATING) **0 1 2 3 4 5 6 7 8 9 10** (MOST DEBILITATING)

Has anyone treated you for this episode(s)? **Y N**

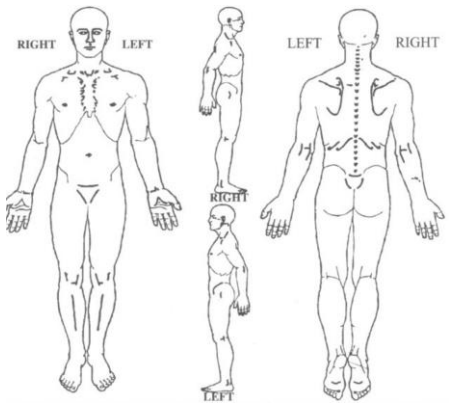
If yes, by whom:_____

What would you like to accomplish from your healing process in our office?_____

_____

Circle the area that shows where you feel pain today. Then indicate the type of pain by using the key below.

Key:
D = Dull
A = Ache
B = Burning
N = Numbness
P = Pins & Needles
S = Stabbing
X = Stiffness
T = Throbbing
O = Other



How did your **symptoms begin**?
- □ Immediately after a specific incident
- □ After multiple incidents
- □ Gradually developed over time
- □ Other:_____

What makes your **symptoms better**?
- □ Nothing □ Laying down
- □ Standing □ Sitting
- □ Movement/Exercise
- □ Other:_____

What makes your **symptoms worse**?
- □ Nothing □ Laying down
- □ Standing □ Sitting
- □ Movement/Exercise
- □ Other:_____

Frequency of pain or symptoms:
- □ Constant (75 – 100%)
- □ Frequent (51 – 75%)
- □ Intermittent (26-50%)
- □ Occasional (25% or less)

Check the best and worst **time of day** for your pain:

Worst	*Best*
□ First Awake	□ First Awake
□ Morning	□ Morning
□ Afternoon	□ Afternoon
□ Evening	□ Evening
□ Other:_____	□ Other:_____

Are your symptoms:

□ Decreasing □ Increasing
□ Not Changing □Other:_____

Description of pain or symptoms:

□ Sharp □ Shooting □ Dull
□ Burning □ Ache □ Numb
□ Weakness □ Tingling □ Throbbing
□ Other:_____

Does your pain **move** or **radiate**? **Y** **N**
Where:_____
How many days out of **an average week** are you in **pain**? _____
How much time **during the day** are you in **pain**? _____
Does the **pain wake you** at night? **Y** **N**

Please indicate if you have pain or symptoms in the following areas *(If you do not have pain, please leave blank)*:

L	R		L	R	
□	□	Ball of Foot or Toe Pain	□	□	Knee pain
□	□	Arch Pain	□	□	Hip Pain
□	□	Heel Pain	□	□	Low Back Pain
□	□	Lower Leg Pain	□	□	Spine Curvature

Chemical Stress:

Please list ALL medications, vitamins, and/or supplements that you are currently taking. Attach a separate sheet if necessary.

Medication	Dosage	Date Prescribed	Reason

Have you received the COVID-19 Vaccine? Y N **Which one?**_____

Have you received any of the COVID-19 Boosters? Y N **How Many?**_____

What is your current work status?

□ Full time, no restrictions □ Full time, restrictions □ Full time Homemaker □ Full time Student
□ Part time, no restrictions □ Part time, restrictions □ Retired □ Unemployed
□ Off work due to restrictions □ Other:_____

Restrictions:

Off work: **Y** **N** **Previously** From:_____to _____

Light duty: **Y N** If yes, what are/were your restrictions?_____

Do/did you require outside help at home? **Y N** If yes, what did you need?_____

Do you wear orthotics or heel lifts? **Y N** Fitted by whom?_____

Is your condition interfering with your: □ Work □ Sleep □ Daily Routine □ Other

Have you seen a chiropractor before? **Y** **N**
If yes: When was your last visit:_____How often did you go?_____
If you stopped, why?_____

Operations/surgeries?_____

Broken bones?_____

Any bad falls?_____

Auto accidents?_____

Hospitalized?_____

Your Birth History:

Was your delivery: □ Natural □ Breech □ C-Section

Was your mother ill prior to her pregnancy with you? **Y N**
Did your mother have a difficult pregnancy with you? **Y N**
Were there any accidents/falls during pregnancy? **Y N**
Instruments used to aid in your delivery: □ Vacuum □ Forceps □ Other:_____
Complications during delivery (chord around neck, prolonged delivery, etc.)? **Y N**
Please explain:_____

Your Birth History (Chemical)

Did your mother take meds/drugs (alcohol, smoking, etc.) prior to her pregnancy with you? **Y N**
Was her labor with you induced or altered? **Y N**
Were you born: □At Home □At a Hospital □At a Birthing Center □Other:_____
How long were you: Breast fed_____ Formula fed_____

Please check the following conditions that you have now or have had in the past:

N = New P= Past B= Both

_____Abdominal Pain
_____Allergies
_____Anemia
_____Appendicitis
_____Arthritis
_____Asthma
_____Bed Wetting
_____Bladder Problems
_____Blurred Vision
_____Bronchitis
_____Bursitis
_____Cancer
_____Carpal Tunnel Syndrome
_____Cold Feet
_____Cold Hands
_____Cold Sweats
_____Cold/Flu
_____Colitis
_____Constipation
_____Cramps
_____Depression
_____Diabetes
_____Difficulty Breathing
_____Diarrhea
_____Epilepsy
_____Fainting
_____Gallbladder Trouble
_____Gas/Gas Pain
_____Gout
_____Groin Pain
_____Headache
_____Hearing Trouble
_____Heart Attack(s)
_____Heart Pain
_____Heart Palpitations
_____Hemorrhoids
_____High Blood Pressure
_____Hip Pain (Sacroiliac)
_____Indigestion
_____Injury Back Pain
_____Kidney Trouble
_____Laryngitis
_____Liver Trouble
_____Low Back Pain
_____Low Blood Pressure
_____Menstrual Irregularity
_____Menstrual Pain (PMS)
_____Muscle Spasm
_____Neck Pain
_____Numbness in Legs
_____Pain Between Shoulders
_____Pain in Feet
_____Pain in Forearm, Elbow
_____Pain in Hand, Wrist
_____Pain in Head, Face
_____Pain in Lower Leg, Knees
_____Pain in Pelvic Region/Thigh
_____Painful Joints
_____Pins & Needles in Hand/Arm
_____Pins & Needles in Legs/Feet
_____Pneumonia
_____Poor Appetite
_____Prostate Problems
_____Ringing or Buzzing in Ears
_____Run Down Feeling (Malaise)
_____Shortness of Breath
_____Sinus
_____Stomach Trouble
_____Stroke
_____Swollen Ankles
_____Tailbone/Sacrum Pain
_____Thyroid Trouble
_____Ulcer(s)
_____Unable to Sleep
_____Varicose Veins

_____ _____

Patient/Guardian Signature **Date**

_____

If guardian, relationship to patient