NAUGATUCK FAMILY CHIROPRACTIC LLC
Confidential Registration & Health Profile

Date _____/_____/_____ Whom may we thank for referring you? _____

Name _____ Birthdate _____

Address _____ City _____

State _____ Zip Code _____ Age _____ Marital Status M S D W

Home Phone (_____) _____ Occupation _____

Work Phone (_____) _____ Employer _____

Cell Phone (_____) _____ Spouse's name _____

Email _____ # of Children / Ages _____

For Women : Are you pregnant? _____ Y _____ N Date of last menstrual period _____

PRESENT HEALTH STATUS & GOALS

1. What is your **PRIMARY** reason for your visit today? _____
2. When did this begin? _____ Related to an accident / injury? ____ Y ____ N
3. Symptoms appeared: _____ Gradually _____ Suddenly
4. How **frequent** are your symptoms? _____ Constant ____ Frequent ____ Intermittent ____ Occasional
5. Type of pain? ___ Aching ___ Burning ___ Numbness ___ Sharp ___ Shooting ___ Stiffness ____Tingling
6. Symptoms are **aggravated** by: _____
7. Symptoms are **reduced** by: _____
8. Rate the **severity** of your symptoms: 0 1 2 3 4 5 6 7 8 9 10
9. What time of day are your symptoms most noticeable? _____
10. Please list any other symptoms, health problems / complaints: _____

_____

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11. Please check all symptoms you have had / are having, **<u>even if they do not seem related</u>** to your current problem.

___ Headaches	___ Neck pain/ stiffness	___ Ear Infections	___ Sinus/ Allergies
___ Freq. sore throat	___ High Blood Pressure	___ Upper Back pain	___ Shoulder / Arm pain
___ Wrist pain/ stiffness	___ Hand numb/ tingling	___ Thyroid conditions	___ Bowel/ Bladder Control Prob
___ Insomnia /Sleep problems	___ Anxiety	___ Asthma/ Chest pains	___ Heart palpatations
___ Digestive issues	___ Low back pain	___ Sciatica	___ Hip pains
___ Knee pains	___ Foot pains	___ Low Energy	___ Leg/ foot numb /tingling

___ Other: _____

12. Do you have a Primary Care Physician? ___ Y ___ N Name: _____

13. **Medication**: Please list all medications, reason for taking and prescribing doctor.

Name: _____ Reason: _____ Dr. _____
Name: _____ Reason: _____ Dr. _____
Name: _____ Reason: _____ Dr. _____
Name: _____ Reason: _____ Dr. _____

_____ I am **NOT CURRENTLY** taking any medications.

14. Vitamins / Natural Remedies: Please list any vitamins, minerals or natural supplements you are taking.

Name: _____ Reason: _____
Name: _____ Reason: _____
Name: _____ Reason: _____

15. Please list **prior surgeries** and dates (from most recent):

Type: _____ Date: _____
Type: _____ Date: _____
Type: _____ Date: _____

16. Please list any **prior significant car accidents / injuries, falls, sports injuries**, & dates

1. _____
2. _____
3. _____

17. Have you ever received **Chiropractic Care**? ____ Y ____ N If **YES**, please see below:

Dr's Name: _____ City / State _____

When? _____ Reason: _____

18. **Social History**

Smoking status: ____ Never ____ Former ____ Daily _____ Occasional Frequency _____ per _____

Alcohol status: ____ Never ____ Former ____ Daily _____ Occasional Frequency _____ per _____

19. **Family Health History**

____ Spinal problems ___ Heart Disease ____ Cancer ____ Arthritis

20. Please list or describe **anything else** you would like the Doctor to know about your **current or past health history**

_____

_____

_____

I certify that the above information is correct to the best of my knowledge. If at any point, any of the previous information changes, I shall notify this office immediately with the correct information. I furthermore give full consent to receive a Chiropractic evaluation and Chiropractic care including, but not limited to spinal adjustments and x-rays if necessary.

SIGNATURE:_____ DATE _____/_____/_____

SIGNATURE OF GUARDIAN, IF PATIENT IS UNDER 18: _____