ADVANCED LASER THERAPY
& CHIROPRACTIC

Patient Registration

Today's Date:_____

First Name:_____ **Last Name**:_____ **Nickname**:_____

Address:_____**City:**_____ **State:**____ **Zip Code:**_____

Mobile: _____ **Home:** _____ **Email:** _____

Date of Birth: _____ **Age:** _____ **Gender:** M F **Marital Status:** S M W D

Spouse Name: _____ **Number of children:** _____

Employer Name: _____ **Occupation:** _____

Who should we thank for referring you to our office? _____

PURPOSE OF THIS VISIT

Main reason for this visit- Chief complaint: _____

When did this condition begin? _____ **Did it begin:** Gradually Suddenly

Type of pain: Sharp Dull Ache Burning Throbbing Spasm Numbness Tingling Shooting

Is this related to an auto accident or work related injury? Yes No **If yes, when** _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? Yes No **Describe:** _____

Does the pain radiate to your arms or legs? Yes No **Is the condition getting worse?** Yes No

How often do you experience these symptoms throughout the day? 100% 75% 50% 25% 10% Only with activity

Does your complaint interfere with: ___ Work ___ Sleep ___ Hobbies ____ Daily Routine

Have you seen anyone else for this? Yes No If Yes, who: _____

What did they do?_____

Please list any other complaints:

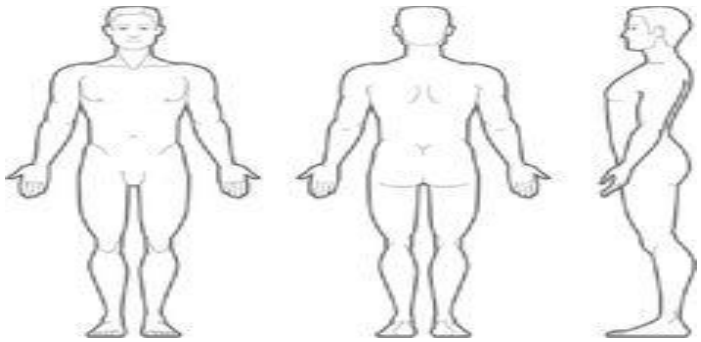
1:_____ 3:_____

2: _____ 4:_____

HEALTH CONDITIONS

Posture distortions are the result of trauma or chronic poor posture. These distortions not only represent a change in the shape of the spine, but the stress it puts on the individual bones causes them to be misaligned from their normal position. This dysfunction, called a subluxation, puts stress on your spinal cord and the delicate nerves that pass between each vertebrae. In the following page mark any health conditions you may be experiencing at present or past.

AREAS OF COMPLAINT – Place "X's" on the area (s) where you have pain and draw lines where it radiates:



Cervical Spine (Neck)

Subluxations in your neck weaken the nerves that go to your shoulders, arms, hands and can cause the following problems, do you have any of these?

___ Neck pain
___ Pain into your shoulders/arms/hands
___ Coldness in hands
___Headaches
___ Numbness/tingling in arms/hands
___ Thyroid condition
___ Dizziness
___ Hearing disturbances
___ Recurrent colds/flu
___ Sinusitis
___ Weakness in grip
___ Low energy/fatigue
___Allergies
___ Visual Disturbances
___ TMJ pain/clicking

Thoracic Spine (Upper and Mid Back)

Subluxations in your upper and mid back weaken the nerves that go to your lings, heart, ribs/chest, and upper digestive tract, do you have any of these?

___ Heart palpitations
___ Heart attacks/angina
___ Recurrent lung infections
___ Heart murmurs
___ Asthma/wheezing
___ Pain on deep inspiration/expiration
___ Tachycardia
___ Shortness of breath
___ Hypoglycemia
___ Mid back pain
___ Reflux
___ Indigestion/heartburn
___ Rib/chest pain
___ Nausea
___ Ulcers/Gastritis

Lumbar Spine (Low Back)

Subluxations in your low back weaken the nerves that go to your lower bowel, pelvic organs, legs and feet, do you have any of these?

___ Pain into your hips/legs/feet
___ Weakness in your hips/knees/ankles
___ Low back pain
___ Muscle Cramps in your legs/feet
___ Constipation/diarrhea
___ Numbness/tingling in your legs/feet
___ Coldness in your legs/feet
___ Frequent/difficulty urinating
___ Cramps in your legs/feet
___ Menstrual irregularities/cramping
___ Sexual dysfunction

Please list any health conditions not mentioned: _____

Please list any medication you are currently taking and their purpose:_____

_____

Please list past surgeries and their year:_____

Please list any previous accidents and injuries: _____

_____

Health Lifestyle

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week

What activities? Running Weights Cycling Yoga Pilates Swimming Other: _____

Do you smoke? Yes No How many per day?_____

Do you drink alcohol? Yes No How many per day?_____

Do you drink caffeinated drinks (coffee/soda/energy drinks) Yes No How much per day?_____

Do you drink water? Yes No How much per day?_____

DO you take supplements (vitamins, minerals, herbs)? Yes No What do you take: _____

Experience with Chiropractic

Have you seen a chiropractor before? Yes No Who?_____ When? _____

Reason for visit? _____

What treatments were given?_____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? Yes No

Are you aware of any of your poor posture habits? Yes No Explain:_____

Payment and Cancellation Policy:

- Payment is expected at the time of service unless some other arrangement has been made between you and the doctor prior to treatment.
- We do not accept any major medical insurance. Payment for treatment can be rendered in the form of cash, check or credit card.
- Should you not be able to be present for your appointment we require 24 hour advanced notice, failure to do so will incur a fee of $20.00 per missed chiropractic appointment/$30 for laser sessions.

By my signature below, I acknowledge that I have completed this intake and agree to the policies above.

_____ _____ _____

Patient's Signature Name (Please Print) Date