Eaton Chiropractic Center

www.EatonChiropractic.Net
109 Dean Street – Taunton, MA 02780
508-823-2697

Patient Registration

Patient Name: _____ Date:_____
Preferred name to be called: _____
Phone: Home:_____ Cell_____
Street:_____
City:_____ State:_____ Zip:_____

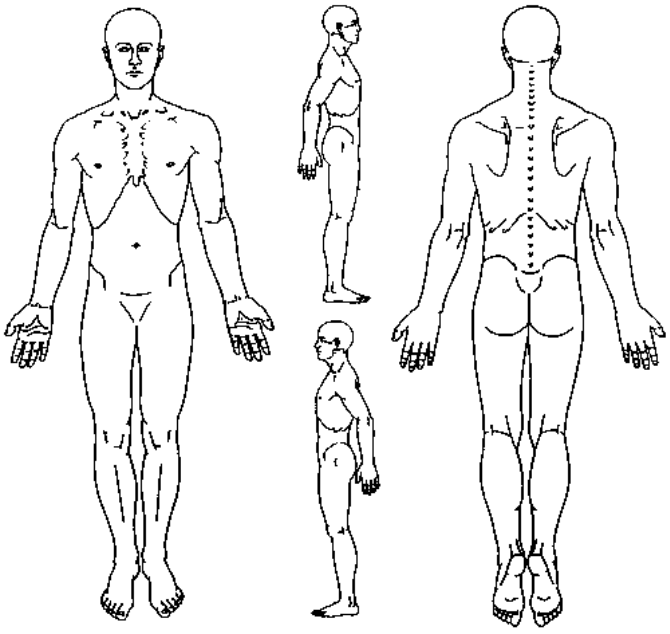
Birth Date:_____ Age:_____ ☐ Male ☐ Female
Social Security #:_____
E-Mail Address:_____
Spouse's Name (or Parent/Guardian):_____

# of Children:_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed
How were you referred to our office?:_____

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation ☐ Other

_____

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Occasionally (26-50%of the time)
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

☐ Sharp ☐ Numb
☐ Dull ☐ Tingly
☐ Diffuse ☐ Sharp with motion
☐ Achy ☐ Shooting with motion
☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric with motion
☐ Stiff ☐ Other:_____

5. How are your symptoms changing with time?

☐ Getting worse ☐ Staying the same ☐ Getting better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*please circle*)

7. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER Physician ☐ Orthopedist ☐ Other
☐ Massage Therapist ☐ Physical Therapist ☐ No One

10. How long have you had this problem? _____

11. How do you think your problem began?_____

12. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

13a. What aggravates your problem?_____

13b. What gives you relief?:_____

14. What concerns you most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ **Weight**_____ **Occupation**_____

16. How would you rate your overall health?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

17. What type of exercise do you do?

☐ Strenuous ☐ Moderate ☐ Light ☐ None

18. Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid arthritis ☐ Diabetes ☐ Lupus

☐ Heart problems ☐ Cancer ☐ ALS

19. For each of the conditions below, place a check in the "past" column if you have had the problem in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High blood pressure	☐	☐	Diabetes
☐	☐	Neck pain	☐	☐	Heart attack	☐	☐	Excessive thirst
☐	☐	Upper back pain	☐	☐	Chest pains	☐	☐	Frequent urination
☐	☐	Mid back pain	☐	☐	Stroke	☐	☐	Smoking/tobacco use
☐	☐	Low back pain	☐	☐	Angina	☐	☐	Drug/Alcohol dependency
☐	☐	Shoulder pain	☐	☐	Kidney stones	☐	☐	Allergies
☐	☐	Elbow/Upper arm pain	☐	☐	Kidney disorders	☐	☐	Depression
☐	☐	Wrist pain	☐	☐	Bladder infection	☐	☐	Systematic Lupus
☐	☐	Hand pain	☐	☐	Painful urination	☐	☐	Epilepsy
☐	☐	Hip pain	☐	☐	Loss of bladder control	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Upper leg pain	☐	☐	Prostate problems	☐	☐	HIV/AIDS
☐	☐	Knee pain	☐	☐	Abnormal weight loss/gain			
☐	☐	Ankle/Foot pain	☐	☐	Loss of appetite	**For Females Only**		
☐	☐	Jaw pain	☐	☐	Abdominal pain	☐	☐	Birth control pills
☐	☐	Joint pain/stiffness	☐	☐	Ulcer	☐	☐	Hormone replacements
☐	☐	Arthritis	☐	☐	Hepatitis	☐	☐	Pregnancy
☐	☐	Rheumatoid arthritis	☐	☐	Liver/Gall bladder disorder			
☐	☐	Cancer	☐	☐	General fatigue			
☐	☐	Tumor	☐	☐	Muscular incoordination			
☐	☐	Asthma	☐	☐	Visual disturbances			
☐	☐	Chronic sinusitis	☐	☐	Dizziness			
☐	☐	Other:_____						

20. List all prescription medications you are currently taking:

_____

_____

21. List all over-the-counter medications you are currently taking:

_____

22. List all surgical procedures you have had:

_____

_____

23. What activities do you do at work?

☐ **Sit**:	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ **Stand:**	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ **Computer work:**	☐ Most of the day	☐ Half of the day	☐ A little of the day
☐ **On the phone:**	☐ Most of the day	☐ Half of the day	☐ A little of the day

24. What activities do you do outside of work? Example Exercise, running, yoga ect…..

_____

24A. Have you ever been to a Chiropractor before? ☐ Yes ☐ No

If yes, when?_____ Did it help you?_____

25: Have you ever been hospitalized? ☐ Yes ☐ No

If yes, why?:_____

26. Have you had significant past trauma? ☐ Yes ☐ No
(Example: Auto accident with significant injuries)

27. Anything else pertinent to your visit today?

_____

We will conduct a thorough history, consultation, and preliminary screening.
If we believe we may be able to help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

I understand and agree to the following
● A history, consultation, and x-rays are conducted for informational purposes. I am requesting these services.
● My case may not be accepted for treatment. If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost.

Patient Signature_____ Date_____