CUMMINGS CHIROPRACTIC OFFICE
REGISTRATION & PATIENT HISTORY

Date _____

Patient Name _____
E-Mail _____
Occupation _____
Employer _____

Primary
Address_____
_____
_____

Secondary
Address_____
_____
_____

Male ____ Female ____ Age _____
Birthdate _____

Single _____ Married _____
Widowed _____ Minor Child _____

Spouse (Companion/Parent)
Name _____

May We Discuss Your Care With This Person? _____

Phones: Home _____
Cell _____
Other _____

Emergency Contact:
Name _____
Relationship _____
Phone _____

Date of Last Chiropractic Treatment _____

Do You:

Smoke _____ Use Alcohol/Illicit Drugs _____

Sleep Well ___ Have Artificial Joints/Appliances ____

Wear Heel Lifts, Inner Soles or Arch Supports _____
Have Allergies _____ (type) _____

Have Prostate Problems (men) _____

Ladies: Are You Pregnant _____ Nursing _____

Menopausal ____ Do You Experience:

PMS ____ Cramping ____ Other ____

Medications:_____
_____
_____
_____
Primary Care Physician: _____

Accidents: Type: Auto: _____ (Date) _____
Fall(s) _____ (Date) _____
Other _____

Surgery(s): (Please explain):
_____
_____
_____
_____

Broken Bones:
_____
_____
_____

Current Complaints: _____
When Did This Problem Begin? _____

Rate your pain's severity (1=minor discomfort, 10=severe pain) ___ Is it constant? ___ Or, does it come & go? ____
It is worse when our are: lying down ____ sitting ___ walking ___ standing still ___ bending ___
Type of pain: Sharp (stabbing) ____ Throbbing ___ Dull Aching ___ Shooting ___ Tingling ___ Numbness ___

PATIENT HEALTH HISTORY:

Have you been treated elsewhere for your condition? _____ Where? _____
When? _____ Method: Medication _____ X-Ray/MRI _____ Surgery _____

Exercise: Light___ Moderate___ Heavy___ None___ Stress Level: Low___ Moderate___ High___
Work Activity: Lifting_____ Bending_____ Sitting_____ Standing_____ Twisting____ Other_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?: (Check for "Yes", leave others blank.)

HEART PROBLEMS:
- Heart Surgery_____
- Arterial blockage _____
- Pacemaker _____
- Heart Attack _____
- Arrhythmia _____

STROKE_____
BLOOD PRESSURE_____
- High_____ Low_____

DIABETES_____
SHINGLES_____
ULCERS_____
HEADACHES_____
DEPRESSION_____
EARS/HEARING:
- Ringing/pressure_____
- Infections_____
- Hearing Loss_____

IMPLANTS_____
ARTIFICIAL JOINTS_____
HERNIA_____
AIDS/HIV_____
POLIO_____

ARTHRITIS:
- Osteo_____
- Rheumatoid_____
- Other _____

GOUT_____
CONSTIPATION_____
DIZZINESS_____
BREATHING DIFFICULTIES
- Tuberculosis_____
- Bronchitis/Emphysema_____
- Pneumonia_____
- Frequent Colds_____
- Asthma_____
- Other_____

EPILEPSY_____
POOR BLADDER CONTROL_____
FREQUENT URINATION_____
THINNING SKIN_____
FREQUENT HEARTBURN_____
PARKINSONS_____
CATARACTS_____
CANCER_____
- Type_____

I UNDERSTAND THAT IT IS VERY IMPORTANT TO PROVIDE A COMPLETE AND ACCURATE HEALTH HISTORY. DR. CUMMINGS RELIES ON DETAILS AND HONESTY AS HE FORMULATES MY DIAGNOSIS AND INDIVIDUAL TREATMENT PLAN.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM DR. CUMMINGS OF ANY CHANGES IN MY HEALTH CONDITION.

_____ _____
Signature (patient/parent/or guardian) Date 5-15-15