VERMONT CHIROPRACTIC & Sports Therapy

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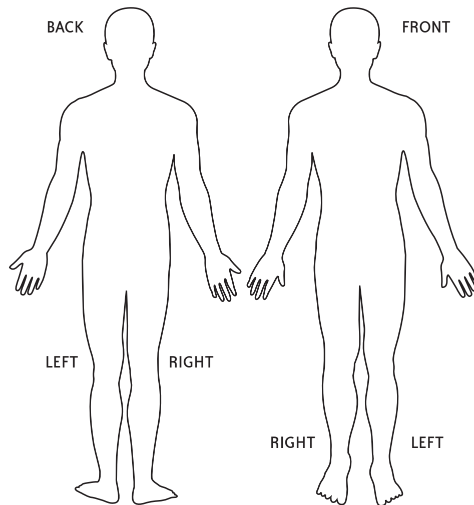
PATIENT REGISTRATION FORM

Name				Home#
address				work#
city-state-zip			age	referred by
name you prefer to be addressed as	date of birth	SS#		Primary care physician
Email Address (optional) For our monthly e-newsletter examining noteworthy health studies				

Please indicate primary complaint (e.g. Headaches, pain in neck, low back, foot etc.)



Use the letters listed below to indicate the type and location of your pain and sensations.

(e.g. if you have stabbing pain in your neck, mark an "S" on the neck where the pain is.)

KEY
A=ACHE
B=BURNING
S=STABBING
N=NUMBNESS
P=PINS & NEEDLES
O=OTHER

Is this pain recurrent? ○Yes ○no
if yes, how often does it recur?

When was the first time you ever suffered from this complaint?

When did this episode begin?

What do you think was the cause of your pain?
(E.G. Car accident, occupation etc.)

What decreases your pain?
(E.G. Pain medication, ice, heat, laying down, stretching etc.)

What increases your pain?
(E.G. Sitting too long, reading, walking, bending etc.)

Have you ever experienced any numbness, pain, weakness, or tingling in your arms, hands, legs or feet? ○Yes ○no
if yes, where?

Please mark a vertical line (|) on each line below to indicate the severity of your pain at it's worst, best and average
(0= no pain 10=most severe pain imaginable)

At It's Worst	**0** --	**10**
At It's Best	**0** --	**10**
On Average	**0** --	**10**

Please list any other treatment that you have ever received for you primary complaint:

Doctor's name and phone#	mri/x-ray results	type of treatment given and the success of the treatment
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Have you ever received treatment from a chiropractor? ○YES ○NO

Have you been involved in any recent trauma (Fall, Accident etc.) ○YES ○NO
(if yes, please describe)

Do any of the following apply to you:

	YES	NO		YES	NO
Loss of Strength	○	○	Unexplained Weight Loss	○	○
Loss of Bladder/Bowel Control	○	○	Fever (over 101), Chills	○	○
Use of Prescription Steroids	○	○	IV Drug Use	○	○
Worse Pain at Night or When Lying	○	○	Night Sweats	○	○

Have you ever had:

○Asthma	○Bleeding Problems	○Blood Clots	○Cancer
○COPD	○Depression	○Diabetes	○Heart Disease
○Hepatitis	○High Blood Pressure	○High Cholesterol	○HIV
○Kidney Disease	○ Liver Disease	○Lung Disease	○Mental Illness
○Osteoporosis	○Stroke	○Other	

Is there chance you might be pregnant? ○YES ○NO

Please list any medications you are taking and the condition that you are taking them for:

I, the undersigned, whose name appears above, hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of the attending physician.
I authorize payment of any medical benefits from my insurance company to be paid directly to Vermont Chiropractic & Sports Therapy for any service rendered to me.

Patient Signature:

Date: