PARKER WELLNESS CENTERS

Welcome, and thank you for choosing our practice for your chiropractic needs. If you have any questions or concerns, do not hesitate to discuss them with us. We will be happy to help you. Please print your answers legibly.

Personal Registration Information

Name_____ **Date**_____
First Middle Last

Address _____
Street City State Zip Code

Phones: Home: _____Work:_____ Cell _____

Do you prefer to receive calls at: Home ☐ Work ☐ Cell ☐ Social Security# _____

Male ☐ Female ☐ Birthdate _____ Single ☐ Married ☐ Divorced ☐ Widowed ☐ # of Children____

Occupation_____ Employer_____

Employer's Address_____

How did you hear about our office? _____

Emergency Contact_____Phone _____ Relationship:_____

Financial Responsibility

Financially responsible person if not patient: _____ Relationship_____

Full address if different than patient: _____

Employer _____ Work Phone _____

If you intend to use insurance to help pay for services, we will need additional forms signed.

Family Health Profile

Please list any blood-related family member who has had: Diabetes, Heart Disease, Cancer, or Stroke:

_____

_____

Daily Habits

Exercise: None ☐ Monthly ☐ Weekly ☐ Type: _____

Work habits: Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Computer Work ☐ Other ☐ _____

Vitamins: No ☐ Yes ☐ Other Nutritional Supplements: No ☐ Yes ☐_____

Smoke: No ☐ Yes ☐ Type_____How much_____ Alcohol: No ☐ Yes ☐ How much _____

How much caffeine do you consume daily from soft drinks, coffee or other source? _____

On a scale of 1 (none) to 10 (extreme) describe your stress level: Personal _____ Work _____

On a Scale of Poor, Good, or Excellent describe your: Diet _____ Sleep _____ Health_____

Please list ***all*** medications you are currently taking, and what for: _____

_____

_____

Are you currently wearing: Heal Lift _____ Arch Support _____ Brace of any kind? _____

Patient Health History **Have you ever had:**

□ AIDS/HIV	□ Chemical Dependency	□ Kidney Disease	□ Rheumatoid Arthritis
□ Alcoholism	□ Depression	□ Knee Problems	□ Rheumatic Fever
□ Allergy Shots	□ Diabetes	□ Liver Disease	□ Scarlet Fever
□ Anemia	□ Emphysema	□ Migraine Headaches	□ Sciatica
□ Anorexia	□ Epilepsy	□ Miscarriage	□ Scoliosis
□ Appendicitis	□ Glaucoma	□ Mononucleosis	□ Stroke (minor or major)
□ Arthritis	□ Goiter	□ Multiple Sclerosis	□ Thyroid Problems
□ Bleeding Disorders	□ Gout	□ Osteoporosis	□ Tonsillitis
□ Breast Lump	□ Heart Disease/Arteriosclerosis	□ Pacemaker	□ Tuberculosis
□ Bronchitis	□ Hepatitis	□ Parkinson's	□ Typhoid Fever
□ Bulimia	□ Hernia	□ Pneumonia	□ Ulcers
□ Cancer	□ Herniated Disc	□ Polio	□ Vaginal Infections
□ Carpal Tunnel Syndrome	□ High Blood Pressure	□ Prostate Problems	□ Whiplash injury
□ Cataracts	□ High Cholesterol	□ Psychiatric Care	□ Whooping cough

□ Any other medical condition(s) not listed above:_____

Please list any: Broken bones_____

Surgeries_____

Allergies to Medications: _____Other allergies: _____

Have you ever had: Chronic ear infections_____ Prolonged use of antibiotics_____ Inhaler_____Asthma_____

Females:

Are you pregnant? No □ Yes □ Nursing? No □ Yes □ Birth Control Pills? No □ Yes □ When_____ Brand_____

Date of last cycle:_____ Was it: Normal □ Painful □ Heavy □ Light □ Cramps □ N/A □

Addressing The Issues That Brought You to Our Office

Where is the problem(s) located?_____

When did you first notice the symptoms?_____

Type of pain:	□ Sharp	□ Throbbing	□ Numbness	□ Aching	□ Shooting	□ Dull
	□ Burning	□ Tingling	□ Cramps	□ Stiffness	□ Swelling	□ Other

Rate the severity of your pain: (1 = mild/discomfort to 10 = severe): 1 2 3 4 5 6 7 8 9 10

Is the condition getting: Better □ Worse □ Is the pain: Constant □ Comes and Goes □

Doctors who have treated you for this condition, and when did you see them? _____

_____

Have you received for your condition: Medication □_____ Surgery □ Physical Therapy □ Other □

Please check all symptoms you have had in the last 6 months, even if they do not seem related to your current condition

□ Headaches	□ Pins/Needles in Legs	□ Fainting	□ Ringing in Ears	□ Mood Swings
□ Dizziness	□ Pins/Needles in Arms	□ Cold Feet	□ Buzzing in Ears	□ Menstrual Pain
□ Neck Pain	□ Numbness in Fingers	□ Cold Hands	□ Depression	□ Menstrual Irregularity
□ Stiff Neck	□ Numbness in Toes	□ Diarrhea	□ Fatigue	□ Hot flashes
□ Back Pain	□ Sleeping Problems	□ Constipation	□ Heartburn	□ Problem Urinating

I certify that I have read and understand the above information to the best of my knowledge. The new patient questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractic doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me - or my child - during the period of such chiropractic care to third party payers and/or health practitioners.
I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____

Signature of patient (or guardian if patient is a minor) **Date**

PARKER
WELLNESS CENTERS

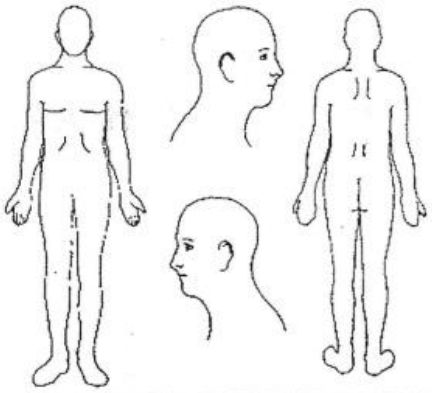
Date of Visit: ___/___/___ Patient: _____ Age: _____

What brought you here today? _____

_____

Place an "X" on the drawing below on areas causing you pain and a letter describing it

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



PAIN SCALE

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

NONE LITTLE MEDIUM SEVERE

Describe your past health history:

Prior Illness: _____

_____

Past Hospitalizations: _____

_____

Surgeries: _____

_____

Medications: _____

Patient Signature: X _____

(DO NOT WRITE BELOW THIS LINE)