

Dale Family Chiropractic, LLC

Patient Registration Form

Name: _____ Sex: Male Female
Spouses Name: _____ Birthdate ____/____/____
Address: _____ Employer: _____
City: _____ Address: _____
State: _____ ZIP: _____ City: _____
State: _____ ZIP: _____
Home: (____) _____ May we leave a message? Yes No
Cell: (____) _____ May we leave a message? Yes No
Work: (____) _____ May we leave a message? Yes No
E-Mail: _____
Marital Status Married Single Divorced Widowed
Spouse's Name: _____
Name(s) and age(s) of children: of Children & ages: _____
Referred By: _____

SIGNATURE: _____ **DATE:** ____/____/____

Patient Primary Complaint Form

Name: _____ Date: _____

What is the number one thing that bothers you the most today?

How did your pain begin? _____

Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Is your condition: Getting Better / Getting Worse

Is your condition: On/off or Constant

Type of Pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore

Radiating: Left/Right / Base of Skull / Shoulder / Arm / Hand

Hip / Leg / Knee / Foot / Rib / other: _____

What Makes it better? Ice / heat / rest / movement / stretching

What Makes it worse? Sitting / standing / walking / lying down / sleep / overuse

Other: _____

Have you had previous Chiropractic Care? [] Yes [] No _____

Have you seen anyone else for this condition? _____

Were you involved in an accident? Auto, Fall, Work, etc? _____

List of medications you are taking: _____

List of past Surgeries: _____

Do you have any other physical complaints? _____

Patient/Parent/Guardian Signature: _____ Date: _____