Patient Registration

Patient Name ______________________________ Nickname ______________
Street ______________________ City ______________ State ______ Zip ________
Home phone ______________________ Work phone ______________________
Mobile phone ______________________ Email ______________________
Family Physician ______________________

Age ________ Date of Birth ____________ Sex ☐ Male ☐ Female
☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced

Patient Employer Name ______________________ Occupation ______________
Street ______________________ City ______________ State ______ Zip ________

Spouse/Parent/Guardian: Name ______________________ Address ______________
Home phone ______________ Employer ______________ Work phone ______________

If you are a student covered under your parents insurance, please complete the following:
Parents' Name ____
Street ______________________ City ______________ State ______ Zip ________
Home phone ______________ Work phone ______________ Mobile phone ______________

Which one of our patients referred you to our clinic? ______________________________

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights is available upon request.

Schofield Chiropractic uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care that you receive.

Schofield Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Schofield Chiropractic may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Schofield Chiropractic may disclose your information for public health activities, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer - Lynn and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Schofield Chiropractic must maintain the privacy of protected health information, provide your with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions of complaints please contact Lynn at 319-277-5616.

______________________________ ______________________
Patient or Guardian Signature **Date**

This form will be retained in your health record.

Schofield
chiropracticgroup

Patient Case History

If you need any assistance completeing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful and educational.

confidential health information

clinic id | date

1 PATIENT INFORMATION

last name | first name | m.i.

2 HEALTH COMPLAINTS

Are you here because you were injured while working, in a motor vehicle collision or in another accident? ☐ yes ☐ no

What services interest you? (mark all that apply)

☐ injury prevention
☐ balance and coordination training
☐ range of motion, mobility or flexibility therapy
☐ treatment for pain
☐ spinal and body alignment
☐ strengthening and stamina exercise
☐ patient education classes
☐ body composition counseling
☐ nutritional and supplement counseling
☐ other ____________________

What is your **primary** complaint?

How long have you been experiencing this **primary** complaint?

How does the **primary** complaint feel? ☐ dull/achy ☐ sharp ☐ numb ☐ tingling ☐ burning

How often do you experience the **primary** complaint? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ yearly

Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

1	2	3	4	5	6	7	8	9	10
no pain or discomfort	slight discomfort	pain that does not affect my activity	pain that affects my daily activities	pain that prevents performing my daily activities	pain that limits my work schedule	pain that prevents working at all	pain that prevents working and all personal activity	pain that keeps me bedridden	pain that causes thoughts of suicide

If you missed work because of your **primary** complaint, what was your last day of work?

What do you believe is causing your **primary** complaint?

List other health complaints (2-5) on the following lines.

2 ____________________ 3 ____________________

4 ____________________ 5 ____________________

Do you have any other condition other than what brings you here? ☐ yes ☐ no

If YES, list it here:

3 LIFESTYLES & HABITS

patient name

How many hours of television do you watch a day? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ > 5

Do you usually snack while watching television? ☐ yes ☐ no

How many hours per day do you use a computer at work or home? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ > 5

How many hours per day do you ride in a car or other vehicle? ☐ < 1 ☐ 1-3 ☐ 3-5 ☐ > 5

How often do you exercise? ☐ daily ☐ 3x/week ☐ 2x/week ☐ I don't exercise

How long do your exercise work outs last? ☐ > hour ☐ 1 hour ☐ 30 minutes ☐ NA

What are your exercise activities? (mark all that apply) ☐ I don't exercise

☐ walking	☐ swimming	☐ weight lifting
☐ stretching/flexibility	☐ yoga/Pilates	☐ resistance bands
☐ running, treadmill, rowing/climbing	☐ group exercise classes	☐ other ______

Do you take a multi-vitamin? ☐ no ☐ yes If YES,what brand do you take?

List any other nutritional supplements you are currently taking.

supplement	reason	supplement	reason
1.		3.	
2.		4.	

How often do you use tabacco? ☐ never ☐ daily ☐ weekly ☐ monthly ☐ yearly

How many servings of alcohol do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ > 5

How many servings of coffee do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ > 5

How many servings of soda do you drink each week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ > 5

4 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

diabetes	n p c mother	n p c father	n p c brother	n p c sister
heart problems	n p c mother	n p c father	n p c brother	n p c sister
kidney problems	n p c mother	n p c father	n p c brother	n p c sister
cancer	n p c mother	n p c father	n p c brother	n p c sister
headaches	n p c mother	n p c father	n p c brother	n p c sister
back pain	n p c mother	n p c father	n p c brother	n p c sister
obesity	n p c mother	n p c father	n p c brother	n p c sister
poor conditioning	n p c mother	n p c father	n p c brother	n p c sister

5 CONDITIONS

Mark the following conditions as they currently pertain to you or have had in the past.

alcoholism ☐ yes ☐ no	goiter ☐ yes ☐ no	mental disorder ☐ yes ☐ no	tuberculosis ☐ yes ☐ no
anemia ☐ yes ☐ no	heart disease ☐ yes ☐ no	mumps ☐ yes ☐ no	venereal infection ☐ yes ☐ no
appendicitis ☐ yes ☐ no	HIV positive ☐ yes ☐ no	pleurisy ☐ yes ☐ no	
arthritis ☐ yes ☐ no	influenza ☐ yes ☐ no	pneumonia ☐ yes ☐ no	whiplash ☐ yes ☐ no
cancer ☐ yes ☐ no	low back pain ☐ yes ☐ no	polio ☐ yes ☐ no	whooping cough ☐ yes ☐ no
epilepsy ☐ yes ☐ no	measles ☐ yes ☐ no	rheumatic fever ☐ yes ☐ no	

6 INJURIES

patient name

List any auto collisions that you were involved in, either as the driver or passenger, below. Begin with the most recent.

type of collision	type of treatment received	date of collision
1.		
2.		
3.		

List any job/sports/other injuries that you experienced below. Begin with the most recent.

type of injury	type of treatment received	date of injury
1.		
2.		
3.		
4.		
5.		

7 HOSPITAL / MEDICINE

Have you had knee or hip replacement surgery? ☐ yes ☐ no

Do you have a pacemaker? ☐ yes ☐ no

Do you have any other implantable medical devices in your body? ☐ yes ☐ no

Mark all of the following procedures as they pertain to you.

vaccinations	☐ yes	☐ no	tubes in ears	☐ yes	☐ no	sinus surgery	☐ yes	☐ no
tonsillectomy	☐ yes	☐ no	appendectomy	☐ yes	☐ no	hernia surgery	☐ yes	☐ no
gall bladder removal	☐ yes	☐ no	female/male surgery	☐ yes	☐ no	thyroid surgery	☐ yes	☐ no
back surgery	☐ yes	☐ no	rectal surgery	☐ yes	☐ no	stomach surgery	☐ yes	☐ no

List any prescription or over-the-counter medications you are currently taking.

medication	reason	medication	reason
1.		3.	
2.		4.	

Have you ever had a lapse of memory? ☐ yes ☐ no Were you ever been knocked unconscious? ☐ yes ☐ no

List any broken bones or dislocations that you had.

Have you ever had a spinal tap or spinal injection? ☐ yes ☐ no List: ______________________

Name of Family Practice doctor: ______________________

List any surgeries/dates: ______________________

____

List previous chiropractic care/dates: ______________________

____

8 SYSTEM REVIEW

patient name

Mark the following conditions that are **currently** a cause of significant concern for you..

General

☐ constant fainting	☐ chills	☐ convulsions	☐ depression	☐ dizziness
☐ loss of weight	☐ fatigue	☐ fever	☐ headache	☐ loss of sleep
☐ weight gain	☐ neuralgia	☐ night sweats	☐ wheezing	☐ nervousness

Gastro-Intestinal

☐ constipation	☐ diarrhea	☐ gall bladder problems	☐ hemorrhoids	☐ jaundice
☐ liver problems	☐ nausea		☐ poor appetite	☐ poor digestion
☐ rectal bleeding	☐ vomiting	☐ stomach pains	☐ vomiting blood	

Eye/Ear/Nose/Throat

☐ asthma	☐ sore throat	☐ nose bleeds	☐ pain in eyes	☐ ear discharge
☐ ear noises	☐ crossed eyes	☐ tonsillitis	☐ earache	☐ hoarseness
☐ nasal obstruction	☐ enlarged thyroid	☐ deafness	☐ hay fever	☐ sinusitus
		☐ frequent colds	☐ poor vision	

Respiratory

☐ chest pain	☐ chronic cough	☐ difficulty breathing	☐ spitting blood	☐ spitting phlegm

Muscles/Joints/Bones

☐ back ache	☐ foot problems	☐ pain between shoulders	☐ painful tailbone	☐ stiff neck
☐ spinal curvature	☐ swollen joints		☐ twitching	☐ weakness
		☐ tremors		

Cardio-Vascular

☐ ankle swelling	☐ high blood press.	☐ low blood press.	☐ heart trouble	☐ pain over heart
☐ poor circulation	☐ rapid heart	☐ slow heart	☐ strokes	

Skin Allergies

☐ bruise easily	☐ dryness	☐ eczema	☐ hives	☐ itching
☐ sensitive skin				

Women

☐ cramps	☐ excessive flow	☐ hot flashes	☐ irregular cycle	☐ painful periods

9 PREGNANCY

WOMEN ONLY

X-rays are contra-indicated during pregnancy. This clinic does not knowingly x-ray women who are or may be pregnant regardless of stage or trimester of pregnancy. If there is a chance that you may be pregnant, let the doctor or assistant know right now.

Are you pregnant? ☐ yes ☐ no On what date did your last period begin?

I understand and agree to the following:

- A history, consultation, examination and x-rays are conducted for diagnostic and informational purposes and I am requesting these services.
- It is my responsibility to complete the clinic's forms accurately.
- It is my responsibility to notify the doctor if any of my information has changed or requires updating.
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request.

patient or guardian signature

date

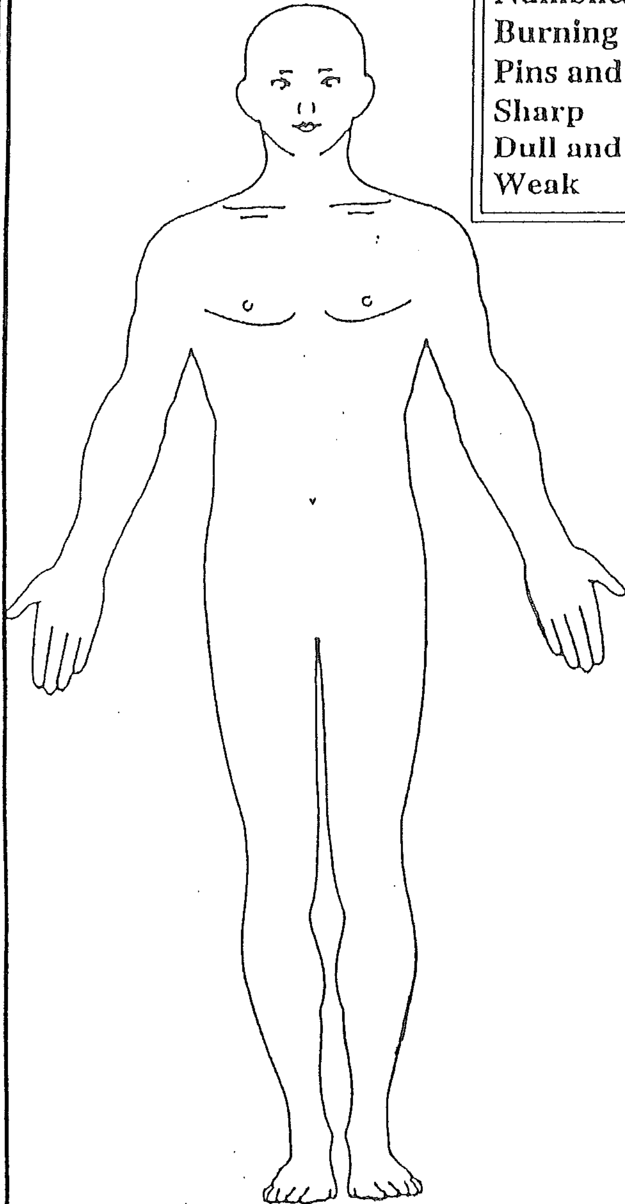
Date

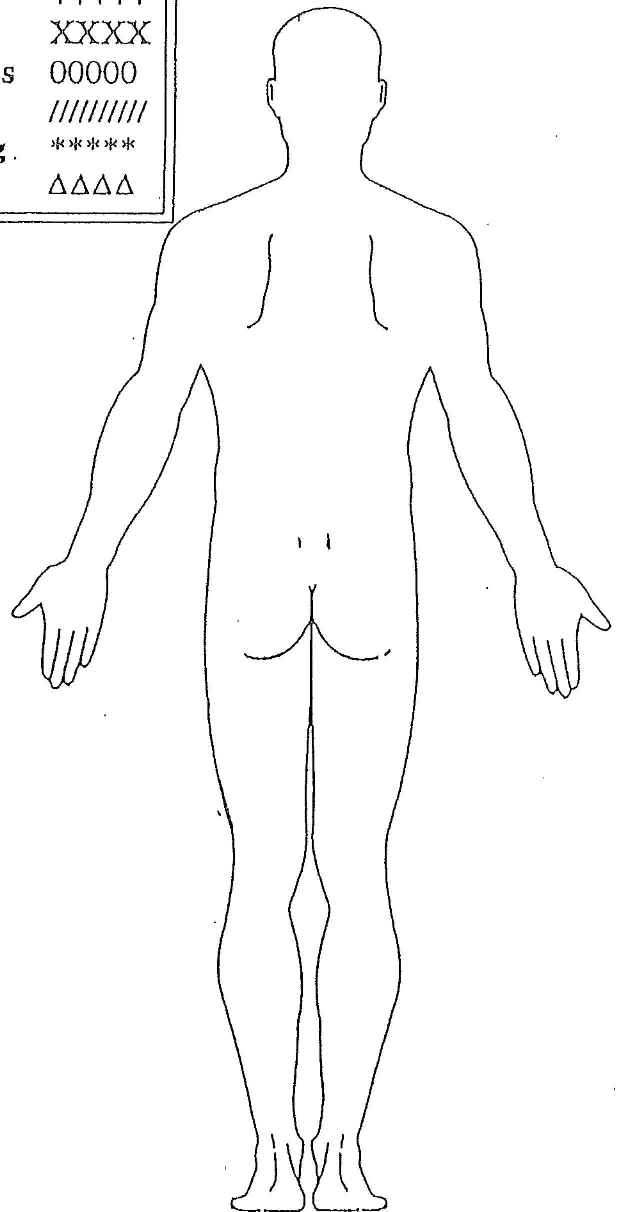
Name

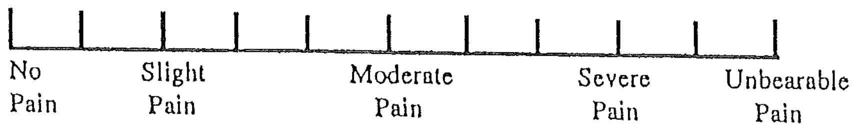
Mark the areas of the body where you feel the described sensations.

Use the appropriate symbol.
Include ALL Affected areas.

Numbness	+++++
Burning	XXXX
Pins and Needles	00000
Sharp	//////////
Dull and Aching	*****
Weak	ΔΔΔΔ







Signature ____________________

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