

Prior Treatment for Main Complaint

Have you seen anyone else for these symptoms? Y / N Who? _____ Dates: _____

What did they recommend? _____ Medications: _____

Test Results for: X-ray _____ CT/MRI _____
Lab _____ Other _____

Injections? Y / N Epidural Facet Other _____ Results: Better No change Worse

Surgery: Year/Type _____ Results: Better No change Worse

Chiropractic: Year/Type _____ Results: Better No change Worse

PT/Other Treatment: Year/Type _____ Results: Better No change Worse

Family Medical History: Anemia Arthritis Diabetes Heart disease High blood pressure
 Lupus Cancer Psoriasis Scoliosis Drug allergies Muscle disease Rheumatoid Arthritis

Living Parents? Mother: Y / N: Died at age ____ of _____

Father: Y / N: Died at age ____ of _____

Your Medical History: Cancer Scoliosis Heart disease GERD Prostate
 Anemia Diabetes Hepatitis Lung disease Diverticulitis Lupus Polio
 Arthritis Glaucoma High BP Kidney disease Tuberculosis Migraine headaches
 Asthma Sinus trouble Lupus Thyroid disease Depression Joint replacement
 Ulcers AIDS/HIV STD Muscle disease Alcoholism Stroke Seizures

WOMEN ONLY: Are you pregnant or is there a possibility you may be pregnant? Y / N / Uncertain

Current Work Status:

Regular Duty Limited/Light Duty: Date began: _____ Off Work: Date began: _____

Lifestyle Habits:

Tobacco ____ (# cigs/day) Sleep ____ (hrs/day) Current exercise ____ (hrs/week)

Alcohol ____ (# drinks/day) Caffeine beverages ____ (# drinks/day)

List Current medications: _____

Drug Allergies: No Yes: _____

Surgeries/Hospitalizations/Fractures/Dislocations:

Year: _____ | _____ Year: _____

Year: _____ | _____ Year: _____

Year: _____ | _____ Year: _____

Have you ever been unconscious? No Yes: When/How? _____

Have you had any of the following recently? (Please check all that may apply):

Constitutional:	<input type="checkbox"/> Fever <input type="checkbox"/> Night sweats	Endocrine:	<input type="checkbox"/> Hot flashes
	<input type="checkbox"/> Unexplained weight loss	Hematological:	<input type="checkbox"/> Bruise easily
Eyes:	<input type="checkbox"/> Abrupt changes of vision	Immunologic:	<input type="checkbox"/> Allergies to pollen, etc.
Ears, Nose, Throat:	<input type="checkbox"/> Abrupt changes in hearing	Genitourinary:	<input type="checkbox"/> Burning/painful urination
	<input type="checkbox"/> Difficulty swallowing		<input type="checkbox"/> Loss of bladder/bowel control
	<input type="checkbox"/> Sore throat <input type="checkbox"/> Deafness		<input type="checkbox"/> Frequent urination
Cardiovascular:	<input type="checkbox"/> Chest pain <input type="checkbox"/> Poor circulation	Infection (recent):	<input type="checkbox"/> Urinary tract <input type="checkbox"/> Respiratory
Respiratory:	<input type="checkbox"/> Cough <input type="checkbox"/> Difficulty breathing		<input type="checkbox"/> Immune system dysfunction
Gastrointestinal:	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting		<input type="checkbox"/> Skin <input type="checkbox"/> Other _____
	<input type="checkbox"/> Bleeding <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoid	Psychosocial:	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety
Musculoskeletal:	<input type="checkbox"/> Pain/swollen joints		<input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Fatigue
Skin:	<input type="checkbox"/> Rash	Female:	<input type="checkbox"/> Excessive menstrual flow
Neurological:	<input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness		<input type="checkbox"/> Cramps or backache
	<input type="checkbox"/> Muscle weakness		

PATIENT REGISTRATION FORM / INSURANCE LOG

Pat Acct # _____

* Patient Name _____ Date _____

Address _____ City/St _____

Zip _____ SS# _____ Sex: M / F Marital: M / S / D / W

DOB _____ Age _____ # Children _____ Spouse's Name _____

* Home Ph # _____ Work Ph # _____ Cell Ph # _____

* Appointment: ___/___/___ __:___ * Doctor: Dr. Robin * How Referred _____

PCP: _____ Adr _____ Ph # _____

Email: _____ Occ: _____ Employer: _____

Emerg Contact: _____ Ph # _____ Relation _____

Patient Initials: _____ *Date:* _____