PATIENT REGISTRATION ACCT#__________ DATE____________

Name_________________________________ Birthdate__________ Age____ Sex: M/F
(First) (MI) (Last)

Address____
(Street) (City) (State) (Zip)

SSN________________________

Home Phone________________ Cell Phone__________________ Work Phone_____________
Email_____________________________________

Race:
__White/Caucasian
__Native Hawaiian/Other Pacific Islander
__Native American/Native Alaskan
__Black/African American
__Asian
__Other: _____________

Ethnicity:
__Hispanic /Latino
__Not Hispanic /Latino

Language: ___________________

Pharmacy Name: ___________________________ Phone Number__________________
Pharmacy Location ___________________________
Primary Care Physician: ________________________ Phone Number__________________

Emergency Contact Person: ______________________ Relationship to Patient: _____________
Home _______________ Cell __________________ Work_________________
* If Patient is a minor, Responsible Party is____

I was referred here by: __ DR: ________________ Website: ________________________
Friend/Family Member ________________________ Other_________________________
I am here today for my: __RT __ LT ______(BODY PART)_______________________________
My pain/problem began on: _____________
What is your pain Level? (1 being No Pain and 10 being the worst) **1 2 3 4 5 6 7 8 9 10**
Have you been treated by any other doctor or facility for this problem? **YES NO**
If yes, please list doctors/facilities treated at: _____________________________________
Please list any medications tried for this problem? (Including over the counter Advil, Aleve, etc.)
____

Are you currently working? **YES NO** ___Full Duty ___Lt Duty ___Retired __Not Employed
Employer Name: ____________________________ Occupation ________________________
Employer Phone________________________

Is this the result of an injury at work? **YES NO** Is this the result of a Motor Vehicle Accident? **YES NO**
Are you currently off work due to this problem? YES NO What was your last day worked? __________
IF YES:
Was your employer informed of your injury? **YES NO**

Name________________________________ ACCT#__________________ DATE__________________

PAST MEDICAL HISTORY

Do you currently have or have had any of the following:

__Diabetes	__Cancer	__Osteoporosis	__Fibromyalgia
__Arthritis	__Pacemaker	__Stroke	__High Blood Pressure
__Liver Problems	__Kidney Problems	__Stomach Ulcers	__Metal Implants
__Hypothyroidism	__Depression/Anxiety/Mental Disorders		__Blood Clots
__Asthma	__Numbness/Tingling	__Stomach Problems	__Wound Healing Problems
__Weight Gain	__Weight Loss	__Heart Problems	__Blood Clots

**If any of the above were checked, please explain: ____

____

**Other medical problems not listed above: ____

Have you ever had an operation for any medical problem? **YES** **NO**

Procedure: ______________________________________ Date or Year Performed ______________

Procedure: ______________________________________ Date or Year Performed ______________

(**If you have had more than two procedures, please list any additional procedures on the back of this sheet)

FAMILY MEDICAL HISTORY

Do any of your parents or siblings **currently have or ever had** any of the following conditions?

__Diabetes	__Cancer	__Osteoporosis	__Fibromyalgia
__Arthritis	__Pacemaker	__Stroke	__High Blood Pressure
__Liver Problems	__Kidney Problems	__Stomach Ulcers	__Metal Implants
__Hypothyroidism	__Depression/Anxiety/Mental Disorders		__Blood Clots
__Asthma	__Numbness/Tingling	__Stomach Problems	__Wound Healing Problems
__Weight Gain	__Weight Loss	__Heart Problems	__Blood Clots

List of Current Medications

_______________ _______________ _______________ _______________

_______________ _______________ _______________ _______________

Do you take blood thinners? (Aspirin, Coumadin, Ticlin, Plavix, Heparin, etc.) **YES** **NO**

Do you have a problem taking aspirin? **YES** **NO**

Do you have any known medication allergies? YES NO (if yes, please list)

_______________ _______________ _______________

(If you have more than 3 allergies, please list any additional allergies on the back of this sheet)

CURRENT HEIGHT: ________ CURRENT WEIGHT: ________

Do you Smoke? **YES** or **No** If you quit, when __________ Do you drink Alcohol? **YES** or **No**

Do you use Recreational Drugs? **YES** or **No**

Are you allergic to or have you ever had any adverse reaction to:

__ Shellfish __Adhesive __Latex ___None

MY LAST BONE DENSITY WAS PERFORMED:

ON/AROUND: ____________________ LOCATION/FACILITY: ______________________________

(Please provide closest date possible)

__NEVER PERFORMED