Genesis
Regeneration 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_________________________________

Email 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 __________________

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**