PATIENT REGISTRATION FORM

Date: ___________________

Patient Contact Information

First Name		*Middle Initial*	*Last Name*	
Date of Birth	*Social Security Number*		*Sex* ☐ *Female* ☐ *Male*	*Age*
Street Address and PO Box(if you have one)				
City	*State*		*Zip Code*	
Home phone		*Work Phone*		
Cell Phone				
Email Address				
Place of Employment and Occupation				
Status(circle one) *Single *Married *Partnered *Widowed *Separated *Divorced				

1. **Preferred Language:** ______________________________
2. **Race (circle one):** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer
3. **Ethnicity (circle one):** Hispanic or Latino / Not Hispanic or Latino / Decline to answer
4. **Tobacco Status:** **NEVER:** Smoker / Chewer
   FORMERLY: Smoker / Chewer
   CURRENTLY: Smoker / Chewer

   If you are currently a smoker, how often? **Light** (1-9 cig./day) **Moderate** (10-19 cig./day) **Heavy** (20-39 cig./day)

Spouse, Guardian or Emergency Contact:

Full Name and Relationship			**Address (if different)**
Home Phone	**Cell Phone (Guardian 1)**	**Cell Phone (Guardian 2)**	**Work Phones for Spouses and Guardians**
Do you want these numbers as your emergency contact? YES NO **If no please fill out the information below.**			
Full Name and Relationship			
Complete Address and Phone Numbers			

How did you hear about our office? ____

Dr. Debra Cheeseman
Dr. John Bosch

Salem Chiropractic Clinic
Stepping up your health
& Rehabilitation

740 South Main Street
PO Box 59
Salem, SD 57058
605-425-2754

Patient Information:

Name: Date:

Health Complaints:

What is your ***primary*** complaint?

____

____

How does the ***primary*** complaint feel? **(Circle all that apply)**

Dull/Achy **Sharp** **Numb** **Tingling** **Burning** **Cold**

Other: ____

How often do you experience the ***primary*** complaint? **(Circle what applies)**

Constantly **Daily** **Weekly** **Monthly** **Yearly** **Other:** ___________________________

What caused your ***primary*** complaint? ____

____

Was it an injury? _______ Date of Injury? __________________ Did it happen at work? _________ If so, have you reported it? ________ Will this be work comp? ________

Have you been seen by any other chiropractor, medical doctor, or other healthcare professional for this condition?

____

What makes the condition worse? **(Circle all that apply)**

Sitting **Standing** **Bending** **Lying** **Walking** **Other:** _____________________

____

What makes the condition better? **(Circle all that apply)**

Sitting **Standing** **Lying** **Walking** **Ice** **Heat** **Other:** _____________

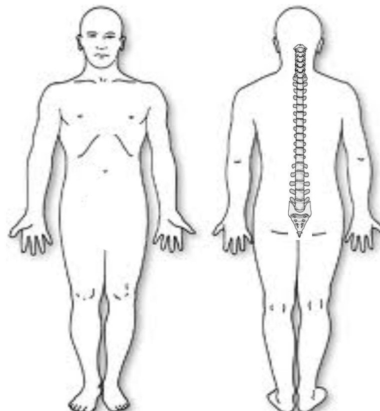
____

Using the scale on the back of this clipboard, rate how your ***primary*** complaint affects your life. **(Circle a number)**

0 **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

No pain **Mild pain** **Severe pain** **Very Severe** **Worst Possible**

Please mark all the areas you are having pain on this diagram to the right:



Office Use Only

Height: __________ **Pulse:** ______

Weight: __________

Blood Pressure: ______________________

Family History:

Please write in the space (M) for Mother, (F) for father, (B) for Brother, & (S) for Sister.

Diabetes: ______________________________ Heart Problems: ______________________________

Kidney Problems: ______________________________ Cancer: ______________________________

Back Problems: ______________________________ Major Illness: ______________________________

Personal History: **Circle all that apply**

Diabetes **Heart Problems** **Kidney Problems** **Cancer** **Back Problems**

Any other major illnesses or medical conditions: ______________________________

____

____

List any Surgeries: ______________________________

____

List all medications or vitamins (prescription & over the counter) and the reason for taking them:

____

____

____

____

List all allergies to any medications:

____

____

____

____

____

Working conditions: **Sitting** **Standing** **Lifting** **Walking** **Other:** ______________________________

____

Exercise & other activities. How frequent?

______________________________ ______________________________

______________________________ ______________________________

Past Injuries:

Car Accidents: Be sure put the dates of the accidents.

____

____

____

____

____

Falls or Other Injuries: Be sure to put the dates of the Injuries.

____

____

____

____

Were X-rays or MRI of the injured area taken within the last 5 years? ______________________________

What Clinic or Doctor? ______________________________

When was the last time you saw a chiropractor? Doctor, Date and Office? ______________________________