

1705 S Pearl St Suite 2, Denver, Colorado 80210

PATIENT REGISTRATION FORM

Today's Date _____

Purpose of Visit: Homeopathy Chiropractic
 Massage Soft Tissue Deep Tissue

SECTION I – PATIENT INFORMATION	
Patient's First Name	Patient's Last Name
Patient's Birth Date	Patient's Age
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Referred by
Height _____ Weight _____	Visit due to Accident? Yes No
Marital Status: Single Married Widowed Divorced	Do you Have Children? Yes No If Yes, Ages:

Home Mailing Address	Business Address
Name (if not the patient)	Employer
Address	Address
City	City
State	State
Zip	Zip
Phone _____ Cell _____	Phone _____
Email	Email
Relationship to Patient Self Mother Father Other	Occupation
Employment: Student Homemaker Full Time Part Time Unemployed Disabled Retired	

Emergency Contact	
Name	Phone

Purpose of Visit: Please describe the current health concerns and/or conditions for which you are seeking help for you or your child. Describe symptoms, ailments and/or complaints and whether acute or chronic. Provide the date on which each condition began.

SECTION II – COMPLETE ONLY FOR PEDIATRIC PATIENTS	
Pregnancy: Circle any that are applicable	High Blood Pressure German Measles Protein in Urine Cigarette Smoking Prenatal Care Gonorrhea/Syphilis sickness Drug/Alcohol Dependence Diabetes/Sugar in Urine
Labor and Delivery: List any problems during labor or delivery	
Birth History: Check any that are applicable	Vaginal Cesarean Anesthesia Forceps Full Term Premature Birth Weight Lengthy Hospital Stay Other; Describe:
Development: Indicate age child entered stages	Teeth Walking Talking
Breastfeeding:	Yes Age No
Childhood Illnesses: Circle if child has experienced any of these illnesses.	High Fever Eczema Mumps Asthma Measles Frequent Colds Diaper Rash Whooping Cough Bronchitis Croup Chicken Pox Pneumonia Ear Infections Tonsillitis Convulsions
Immunizations: Indicate the age(s) at which these immunizations were given	Diphtheria Tetanus Measles Rubella Pertussis Polio Mumps Hepatitis
Hospitalizations: Describe reasons for any hospitalizations and/or surgeries	
Other Medical Problems:	

Describe any significant medical problems		
SECTION III – PATIENT'S HEALTH AND MEDICAL HISTORY		
Medications: Please list the name and dosage of currently or previously used medications		
Description	Current	Past
Topical Ointments		
Antibiotics		
Antihistamines		
Vitamins, supplements		
Steroids (cortisone pills, sprays, ointments or injections) Include dose and date		
Other non-prescriptions		
Other prescriptions, including birth control		
Allergies to medications		

Medical Conditions: Circle applicable conditions previously diagnosed and/or experienced

Neck pain with movement	Wheezing or Asthma	Hepatitis	Bronchitis
Stiff Neck	Coughing spells	Diabetes	Pneumonia
Grinding/Popping sounds	Chest pains	Cancer	Mumps
Headaches	Numbness/Tingling	Rheumatic Fever	Burping or gas
Entire head	Leg cramps	Thyroid disease	Abdominal pain
Back of head	Feet feel cold	Arthritis	Nausea
Forehead	Swollen ankles	Bursitis	Frequent vomiting
Migraines	recurrent fevers	Measles	Diarrhea
Head feels heavy	Shooting pains in hips/legs/feet	Chicken Pox	Constipation
Loss of memory	Seizure/Convulsions	Food allergies	Eczema or skin rashes
Lights both eyes	Can't raise arm above shoulder	Eyes crossing	Frequent urination
Dizziness/Loss of balance	Can't raise arm over head	Visual problems	Pain from urination
Ringing in ears	Cold hands	Wears glasses/Contact	Nasal congestion
Frequent ear infections	Loss of grip strength	Eye irritation	High or low appetite
Difficulty hearing	Shooting pains in arms/hands	Speech impediment	Weight gain or loss
Heart disease	Sore throats	Shortness of breath	Bleeding problems
Ear drainage	Low Back; Pain is worse when	Dental problems	Warts
Sinus/Allergies	liffing	TMJ	Allergies to animals
Hay fever	sitting	Teeth grinding	Tonsillitis
Discharge from penis or vagina	lying down	Dental splint tiredness	Pregnant # months
High blood pressure	bending	Frequent colds	Menstrual pain
Low blood pressure	coughing	Nose bleeds	Irregular cycle
	working		

FAMILY: Please list any patient family members' medical problems. Indicate Brother (Br) or Sister (Sis) by circling the correct initials.

	Father	Mother	Br/Sis	Br/Sis	Br/Sis	Br/Sis	Father's Mother	Father's Father	Mother's Mother	Mother's Father	Other	Other
Age												
Deceased (age)												
Living With You												
Allergies												
Arthritis												
Asthma												
Cancer												
Diabetes												
Heart and High BP												

All information is used solely for the purposes of providing care and remains confidential.