REGISTRATION AND APPLICATION FOR CARE

PATIENT INFORMATION

Name ______________________________

Email ______________________________

Address ______________________________

____
City State Zip

Sex: M F Age ______ Birthdate ____ / _____ / _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Spouse's Name ______________________________

Children, Ages ______________________________

____

Dentist ______________________________

Medical Doctor ______________________________

Occupation ______________________________

Employer ______________________________

Whom may we thank for referring you? ______________

____

For Office use only

Height: __________ *Weight:* __________ *B.P.*:___________

ELECTRONIC HEALTH RECORDS

PREFERRED LANGUAGE: ____________________

CMS requires providers to report both race and ethnicity

RACE:

❑ White/(Caucasian)

❑ Black/African-American

❑ Asian

❑ Native Hawaiian or Pacific Islander

❑ American Indian or Alaska Native

❑ Other ❑ I Decline to Answer

ETHNICITY:

❑ Non-Hispanic/Latino

❑ Hispanic/Latino

❑ I Decline to Answer

CONTACT INFO

Home ___________ Work ___________ Cell ___________

In case of emergency, contact: ________________________@

Home ___________ Work ___________ Cell ___________

Preferred method of communication for patient reminders:

❑ Email ❑ Phone/Text ❑ Mail

❑ I choose to decline receipt of my clinical summary after each visit *(These sumaries are often blank as a result of the nature and frequency of chiropractic care)* _______ (initial)

ACCIDENT INFORMATION

Is condition due to an accident? Y N Date ____________ Type of accident: ❑ Auto ❑ Work ❑ Home ❑ Other: __________

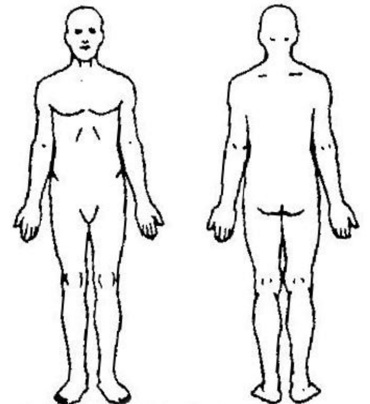
To whom have you made a report of your accident? ❑Police ❑Auto Insurance ❑Employer ❑Worker ❑Other: _____________

PATIENT CONDITION

Reason for visit ______________________________

When did your symptoms appear? ______________________________

Is this condition getting progressively worse? Y N **Mark the location of your symptoms** ⇨



Rate the severity of your symptoms from 1 (least) to 10 (severe) pain: ____________________

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numb ❑ Aching ❑ Shooting

❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other: ___________

How often? ❑ Constant ❑ Daily ❑ Couple/Week ❑ Weekly ❑ Other: _________________

Does it interfere with ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation ❑ Other:___________

Activities that are difficult ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

❑ Other: ______________________________

Doctors seen for condition, tests performed: ______________________________

Other information the doctor should know: ______________________________

HEALTH HISTORY

Please mark the appropriate column (C = Current, P = Past) to indicate if you have had any of the following:

C	P	General	C	P	Muscle / Joint	C	P	E.E.N.T.	C	P	Cardiovascular
☐	☐	Allergy	☐	☐	Arthritis	☐	☐	Colds	☐	☐	Hardening Arteries
☐	☐	Chills	☐	☐	Bursitis	☐	☐	Crossed Eyes	☐	☐	High Blood Pressure
☐	☐	Convulsions	☐	☐	Hernia	☐	☐	Deafness	☐	☐	Low Blood Pressure
☐	☐	Depression	☐	☐	Low Back Pain	☐	☐	Earache	☐	☐	Pain Over Heart
☐	☐	Dizziness	☐	☐	Neck Pain / Stiffness	☐	☐	Ear Noises	☐	☐	Cold Hands or Feet
☐	☐	Fainting			*Pain or Numbness:*	☐	☐	Enlarged Glands	☐	☐	Rapid Heart Beat
☐	☐	Headache	☐	☐	Between Shoulders	☐	☐	Eye Flashes	☐	☐	Slow Beating Heart
☐	☐	Loss of Sleep	☐	☐	Shoulders	☐	☐	Eye Pain	☐	☐	Swelling Ankles
☐	☐	Loss of Weight	☐	☐	Arms	☐	☐	Hay Fever	☐	☐	Varicose Veins
☐	☐	Nervousness	☐	☐	Elbows	☐	☐	Hoarseness			**Skin**
☐	☐	Tremors	☐	☐	Hands	☐	☐	Nasal Obstruction	☐	☐	Bruise Easily
		G-I	☐	☐	Hips	☐	☐	Nosebleeds	☐	☐	Dryness
☐	☐	Belching / Gas	☐	☐	Legs	☐	☐	Sinus Infection	☐	☐	Hives or Allergy
☐	☐	Colon Trouble	☐	☐	Knees	☐	☐	Sore Throat	☐	☐	Itching
☐	☐	Constipation	☐	☐	Feet			**Genito-Urinary**	☐	☐	Skin Lesions (Rash)
☐	☐	Diarrhea	☐	☐	Painful Tailbone	☐	☐	Bed Wetting			**Women Only**
☐	☐	Difficult Digestion	☐	☐	Sciatica	☐	☐	Blood in Urine	☐	☐	Cramps / Backache
☐	☐	Gall Bladder Trouble	☐	☐	Swollen Joints	☐	☐	Frequent Urination	☐	☐	Excessive Flow
☐	☐	Hemorrhoids			**Respiratory**	☐	☐	Can't Control Urine	☐	☐	Hot Flashes
☐	☐	Jaundice	☐	☐	Chest Pain	☐	☐	Painful Urination	☐	☐	Irregular Cycle
☐	☐	Liver Trouble	☐	☐	Chronic Cough	☐	☐	Prostrate Trouble	☐	☐	Lumps in Breast
☐	☐	Nausea	☐	☐	Difficult Breathing	☐	☐	Puss in Urine	☐	☐	Menopausal Symptoms
☐	☐	Pain Over Stomach	☐	☐	Coughing up Blood				☐	☐	Painful Period
☐	☐	Ulcers	☐	☐	Spitting up Phlegm				☐	☐	Vaginal Discharge
			☐	☐	Wheezing				☐	☐	Miscarriage

List all medically diagnosed conditions: ____

List all injuries and dates: (including falls, broken bones, dislocations, etc.): ____________________

____

List all surgeries and dates, including outpatient: ______________________________________

____

Medications ⇩	Dose / Frequency	Medication Allergy	Reaction (details)	Onset Date

Exercise	Work Activity	Habits		Women Only
❑ None	❑ Sitting	Smoke ❑Never ❑Former ❑Occasional ❑Daily		
❑ Moderate	❑ Standing	❑ Alcohol	Drinks / Week _____	Last Period ___________
❑ Daily	❑ Light Labor	❑ Coffee / Caffeine	Cups / Day _______	Are you pregnant? Y N
❑ Heavy	❑ Heavy Labor	❑ High Stress Level	Reason ____________	Due Date _____________

I verify that all information is accurate and complete. (As a parent or legal guardian, I give consent for care.)

Name: ____ Date _______ / _______ / _______

Hilsman Chiropractic P.C. ◆ 400 136th Ave Ste 413 ◆ Holland MI 49424 ◆ ph. 616-355-5444 fax. 616-953-0528