Aspen Chiropractic Clinic, LLC
7417 SW Beaverton Hillsdale Hwy | Ste 200
Portland OR | 97225
503.291.7155

Patient Registration for Health Concerns

The information you provide is confidential and will not be reproduced or shared without your permission unless permitted by law.

First name ______________________ **MI** ____ **Last name** ______________________________

Gender ______ **Birth date** ________________ **Drivers license #** ______________________ **State:** ________

Home address ____________________________________ **City** ______________ **State** ____ **Zip** ________

Home phone # ______________________________ **Mobile /Voice mail #** __________________________

Your occupation ______________________________________ **Your work status** [circle one] Full time Part time

Your employer ____________________________________ **Work phone #** __________________________

Employer address ____________________________ **City** ______________ **State** ________ **Zip** __________

[circle one] **Spouse, Partner or Parent name** ________________________ ***Their phone #*** ____________________

Emergency contact person ______________________________ ***Their phone #*** ____________________

Who referred you or how did you hear about this office? ______________________________________

Who is filling out this questionnaire? __________________________ ***Relationship to patient:*** ____________

Your Primary Care Physician __________________________ ***Phone# or Location*** ____________________

Reason for your office visit: *Please summarize why you are visiting our office. You may indicate more than one health concern.*

____

What do you think caused your current condition? [circle below] ***When did it begin?*** ____________________

Auto accident *Other accident or injury* *Work injury* *Illness* *Congenital condition* *Unknown*

Has another doctor treated you for your current condition? [circle one] Yes No ***Still treating?*** [circle one] Yes No

Name of doctor ____________________________________ ***Phone# or Location*** ____________________

Have x-rays or MRI films been taken for your current condition? [circle one] Yes No ***When?*** ________________

What other tests have been done to diagnose or monitor your current condition? ____________________

____

Please list all medicines you are taking even if they are over-the-counter drugs, herbs or vitamins:

Name	*Why do you take it?*	*What dosage?*	*Taken for how long?*

Are you allergic to anything (medications, soaps, lotions, foods)? [circle one] Yes No ***If YES, please explain:*** ________

____

Is there anything else you think your doctor should know? ______________________________________

____

Signature ____________________________________ **Date** ____________________

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Health History

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Personal History

Name ____________________ **Date of Birth** ____________ **Age** ________

[circle one] **Right handed** **Left handed** **Ambidextrous** **Your HEIGHT:** ________ *feet* ________ *inches*

Your *current* WEIGHT: ________ *pounds* **Your *normal* WEIGHT:** ________ *pounds*

Have you recently gained or lost a significant amount of weight? [circle one] **Yes No** *If YES, how much and over what time period?* ____________________

***Female patients*, please answer the following questions:**

Are you pregnant, or do you have any reason to believe that you could be pregnant? [circle one] **Yes No**

Number of children ________ **Number of pregnancies** ________ **Number of births** ________

Social History *Please check the appropriate column if any of the following apply to you:*

PAST	PRESENT		
☐	☐	Tobacco	Per day ______ or per week ______
☐	☐	Alcohol	Per day ______ or per week ______
☐	☐	Caffeinated drinks	per day ______ or per week ______
☐	☐	Decaffeinated coffee	per day ______ or per week ______
☐	☐	Drugs and related substances	

Past Health History

PRIOR INJURIES

Please list all major past injuries, even if you never received medical care

INJURY	DATE OCCURRED	WORK RELATED [yes or no]	DOES THE CONDITION RECUR [yes or no]

PRIOR ADULT ILLNESSES

Please list all serious illnesses, such as *ASTHMA, CANCER, DIABETES, HEART DISEASE, HEPATITIS, HIGH BLOOD PRESSURE, HIV INFECTION, SEIZURES, SICKLE CELL ANEMIA, TUBERCULOSIS.*

DATE	DIAGNOSIS	TREATMENT GIVEN	ANY REMAINING PROBLEMS?

PRIOR SURGERIES & HOSPITALIZATIONS

Please list all major surgeries/ operations and times you were hospitalized, even if you never had surgery

DATE	TYPE OF SURGERY OR CAUSE OF HOSPITALIZATION	ANY COMPLICATIONS?	ANY REMAINING PROBLEMS?

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Family History ***Please tell us about your birth parents and blood relatives if this information is available to you***

Mother is [circle one] **LIVING DECEASED Age________Cause of death____________________________**

Father is [circle one] **LIVING DECEASED Age________Cause of death____________________________**

Please check the appropriate column if any of the following apply now or in the past to your blood relatives

- ☐ **Alcoholism**
- ☐ **Allergies**
- ☐ **Arthritis**
- ☐ **Anemia, blood, bleeding disorders**
- ☐ **Cancer**
- ☐ **Diabetes mellitus**
- ☐ **Heart Disease**
- ☐ **Inherited disorder ________________________________**

Your Symptoms List ***Please check the appropriate column for symptoms you have experienced before (PAST) or for symptoms you currently experience (PRESENT)***

PAST	PRESENT	
☐	☐	General fatigue
☐	☐	Headache
☐	☐	Tinnitus, noises in the ear
☐	☐	Fainting
☐	☐	Vision disturbances
☐	☐	Convulsions
☐	☐	Dizziness, lightheadedness
☐	☐	Muscular incoordination
☐	☐	Generalized muscle pain
☐	☐	TMJ (jaw) pain
☐	☐	Neck pain
☐	☐	Back pain
☐	☐	Joint swelling
☐	☐	Joint stiffness
☐	☐	Shoulder pain
☐	☐	Arm pain
☐	☐	Elbow pain
☐	☐	Wrist, Hand pain
☐	☐	Hip pain
☐	☐	Leg pain
☐	☐	Knee pain
☐	☐	Ankle, foot pain
☐	☐	Enlarged lymph nodes, glands

PAST	PRESENT	
☐	☐	Skin rash, dermatitis, eczema
☐	☐	Chronic sinus problems
☐	☐	Excessive thirst
☐	☐	Chronic cough
☐	☐	Chest pain
☐	☐	Rapid heart beat
☐	☐	Difficulty swallowing
☐	☐	Heartburn and/ or indigestion
☐	☐	Loss of appetite
☐	☐	Nausea
☐	☐	Abdominal pain
☐	☐	Loss of bladder or bowel control
☐	☐	Painful urination
☐	☐	Frequent urination
☐	☐	Difficult urination or changes in stream
☐	☐	Constipation
☐	☐	Irregular bowel habits
☐	☐	Irregular menstrual flow
☐	☐	Excessive menstrual flow
☐	☐	Breast tenderness and/ or lumps
☐	☐	Vaginal discharge
☐	☐	PMS
☐	☐	ED

Signature ____ **Date______________________**

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