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

Name of provider _______________________________________***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 provider 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		PAST	PRESENT	
☐	☐	General fatigue	☐	☐	Skin rash, dermatitis, eczema
☐	☐	Headache	☐	☐	Chronic sinus problems
☐	☐	Tinnitus, noises in the ear	☐	☐	Excessive thirst
☐	☐	Fainting	☐	☐	Chronic cough
☐	☐	Vision disturbances	☐	☐	Chest pain
☐	☐	Convulsions	☐	☐	Rapid heart beat
☐	☐	Dizziness, lightheadedness	☐	☐	Difficulty swallowing
☐	☐	Muscular incoordination	☐	☐	Heartburn and/ or indigestion
☐	☐	Generalized muscle pain	☐	☐	Loss of appetite
☐	☐	TMJ (jaw) pain	☐	☐	Nausea
☐	☐	Neck pain	☐	☐	Abdominal pain
☐	☐	Back pain	☐	☐	Loss of bladder or bowel control
☐	☐	Joint swelling	☐	☐	Painful urination
☐	☐	Joint stiffness	☐	☐	Frequent urination
☐	☐	Shoulder pain	☐	☐	Difficult urination or changes in stream
☐	☐	Arm pain	☐	☐	Constipation
☐	☐	Elbow pain	☐	☐	Irregular bowel habits
☐	☐	Wrist, Hand pain	☐	☐	Irregular menstrual flow
☐	☐	Hip pain	☐	☐	Excessive menstrual flow
☐	☐	Leg pain	☐	☐	Breast tenderness and/ or lumps
☐	☐	Knee pain	☐	☐	Vaginal discharge
☐	☐	Ankle, foot pain	☐	☐	PMS
☐	☐	Enlarged lymph nodes, glands	☐	☐	ED

Signature ____ Date________________________

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