# REGISTRATION & HISTORY

## Allen HealthCare Solutions

Seth Allen MA, DC, DACBN

Date:

Patient Name: (Last) (First) (MI)

Date of Birth: Age: Gender: Male/Female

Address: (Street) (City/State) (Zip code)

Home Phone: Cell Phone: Work Phone:

Occupation: Place of Employment:

❑ Minor ❑ Single ❑ Separated Parent or

❑ Married ❑ Widowed ❑ Partnered Spouse's name:

Emergency Contact Name: Relationship:

Emergency Contact Number:

How Did You Hear About Us?

### Patient Condition

Please list the symptoms you are seeking treatment for today (most severe to least severe):

When did your symptoms appear and how did they start?

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

How often do you have this pain? _____

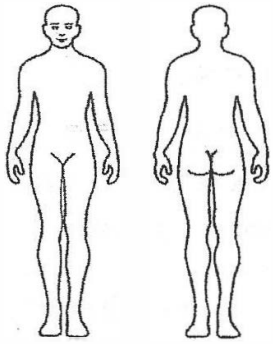
Is it constant or does it come and go? _____

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform:

❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

Mark an X here on the pictures where you continue to have pain, numbers, or tingling



Is this condition due to an accident? ❑ Yes ❑ No Date: _____

Type of Accident: ❑ Auto ❑ Work ❑ Home ❑ Fall ❑ Other

# HEALTH HISTORY

What treatment have you already received for your condition?

❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic Services ❑ None ❑ Other: _____

Name of the other doctor(s) that have treated you: _____

X-rays, MRI, CT-scan, Bone scan ❑ Yes ❑ No When?_____

*Please circle any condition that applies to your health:*

Heart Disease
Arrhythmia
Pacemaker
Heart Attack
High Blood Pressure
Anemia
Lung Disorder
Asthma
Eye Disorder
Glaucoma
Cataracts
Diabetes
HIV/AIDS
Hepatitis
Tuberculosis
Mononucleosis
Liver Disease

Kidney/Bladder Disease
Osteoarthritis
Rheumatoid Arthritis
Hearing Loss
Stroke
Parkinson's Disease
Pinched Nerve
Irritable Bowel Syndrome
Acid Reflux
Hiatal Hernia
Ulcers
Constipation
Diarrhea
Thyroid Disorder
Skin Disorder
Migraine/Other Headaches

Anxiety
Depression
Bipolar
Prosthesis
Metal Implants: Where:
Scoliosis
Herniated Disk
Osteoporosis
Fracture: Spinal
Chronic Fatique
Fibromyalgia
Insomnia
Cancer:_____Treatment_____

Other:_____
_____
_____

Height:_____ Weight:_____

Allergies:_____
_____
_____
_____

Vitamins/Herbs/Minerals: _____
_____
_____
_____

Surgeries:_____
_____
_____
_____
_____

Accidents: _____
_____
_____
_____

Medications: _____
_____
_____
_____

_____
_____
_____
_____

**Lifestyle**

Exercise: ❑ None ❑ _____x per Week Type:_____

Work Activity: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Habits: ❑ Smoking____PPD ❑ Alcohol_____Drinks/wk ❑ Caffeine/Coffee_____Cups/day

❑ Soda Regular/Diet_____Cans/day

High Stress: ❑ Personal ❑ Job Related