# Well Balanced Chiropractic

1021 Sandusky St. Suite B
Perrysburg, OH 43551
Sarah E. Dumas, D.C.

## Patient Registration

**Patient Contact**

Title: Mr./Mrs./Ms./Dr./Rev./Rank _____ Date: _____

Last Name_____ First Name_____ M.I._____ Nickname _____

Address_____City_____ State_____ Zip _____

Home Phone_____ Mobile Phone_____

Work Phone_____ E-mail_____

**Patient Personal**

Age_____ Date of Birth_____ Gender: Male Female

Social Security #_____

Employer Name_____ Occupation_____

Marital Status: Single Married Widowed Separated Divorced

Spouse Name_____ Employer_____Phone_____

Children (names & ages)_____

**Emergency Contact**

Name_____ Relationship_____

Home Phone_____ Mobile Phone_____ Work Phone_____

Most patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Friend or family member name_____

▫Yellow Pages ▫Website ▫Presentation ▫Sign ▫Newspaper ▫Other_____

Have you ever received chiropractic care? Yes No

If yes, when and where? _____

Do you have health insurance? Yes No If yes, company? _____

Who is your:

Primary Care Physician_____ Last Visit_____

Massage Therapist_____ Last Visit_____

# Patient Case History

## I. Health Complaints

□ I have no health complaints, I am interested in prevention and health maintenance (skip to section II)

What is your PRIMARY complaint?_____

List other health complaints on the following lines:

2_____ 3_____

4_____ 5_____

6_____ 7_____

How long have you been experiencing the **PRIMARY** complaint?_____

How does the **PRIMARY** complaint feel? □dull □sharp □numb □tingling □burning □spasm □other_____

How often do you experience the **PRIMARY** complaint? □ constantly □ daily □ weekly □ monthly □ yearly

What makes your **PRIMARY** complaint better?_____ worse?_____

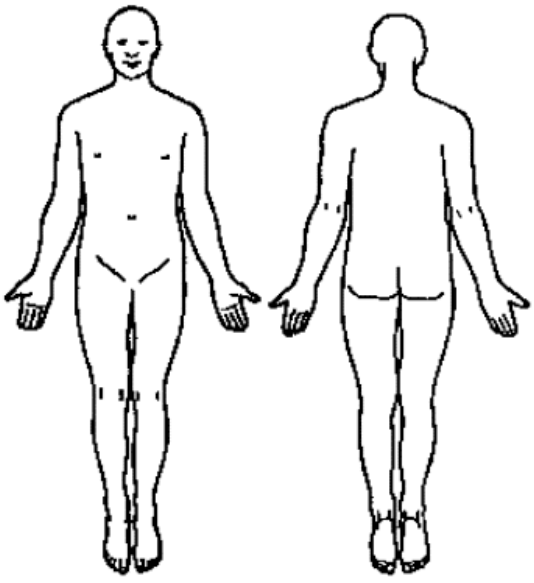
Have you missed any work or school because of your **PRIMARY** complaint? yes no

How does your **PRIMARY** complaint affect you at home/work/school?_____

Have you had any prior treatment for your primary complaint?_____

What do you believe is causing your **PRIMARY** complaint?_____

Please mark the areas of all of your complaints on the diagrams to the right



## II. Health History

Are you pregnant? Yes No Unsure If yes, how many weeks?_____

How often do you use tobacco? ▫ never ▫ daily ▫ weekly ▫ monthly

How many servings of alcohol do you drink each week? ▫ 0 ▫ 1-2 ▫ 3-5 ▫ 6-9 ▫ 10-20 ▫ >20

How many servings of coffee do you drink each week? ▫ 0 ▫ 1-2 ▫ 3-5 ▫ 6-9 ▫ 10-20 ▫ >20

How many servings of soda do you drink each week? ▫ 0 ▫ 1-2 ▫ 3-5 ▫ 6-9 ▫ 10-20 ▫ >20

How many glasses of water do you drink each day? ▫ 0 ▫ 1-2 ▫ 3-5 ▫ 6-9 ▫ 10-20 ▫ >20

How many times do you eat per day? ▫ 1 ▫ 2 ▫ 3 ▫ 4 ▫ >5

How many servings of fruits and vegetables do you eat per day? ▫ 0 ▫ 1-2 ▫ 3-5 ▫ 6-9 ▫ >9

How often do you exercise? ▫ daily ▫ 5x/week ▫ 4x/week ▫ 3x/week ▫ 2x/week ▫ 1x/week ▫ I don't exercise

How long do your workouts last? ▫ <30 minutes ▫ 30 minutes ▫ 1 hour ▫ > 1 hour

What are your exercise activities? (mark all that apply)

▫ walking ▫ swimming ▫weight lifting ▫ stretching/flexibility ▫ resistance bands

▫ running/treadmill/rowing ▫ yoga/pilates ▫ group exercise classes ▫ other_____

Please mark any of the following that apply to you?

| | | | |
|---|---|---|---|
| ▫ Headaches | ▫ Wrist/Hand Pain | ▫ Hepatitis | ▫ Low Back Pain |
| ▫ Seizures | ▫ Upper Back | ▫ Gallbladder Removed | ▫ Hip Pain |
| ▫ Multiple Sclerosis | ▫ Mid Back Pain | ▫ Diabetes | ▫ Knee Pain |
| ▫ Visual Problems | ▫ Asthmas | ▫ Anemia | ▫ Ankle/Foot Pain |
| ▫ Allergies/Sinus | ▫ Chest Pain | ▫ IBS | ▫ Cancer |
| ▫ Ringing in Ears | ▫ High Cholesterol | ▫ Digestive Problems | ▫ Arthritis |
| ▫ Neck Pain | ▫ High Blood Pressure | ▫ Constipation | ▫ Autoimmune |
| ▫ Hypothyroidism | ▫ Acid Reflux/Indigestion | ▫ Hemorrhoids | ▫ Fibromyalgia |
| ▫ Shoulder Pain | ▫ Muscle Spasms/Cramps | ▫ Menstrual Issues | ▫ Weight (gain/loss) |
| ▫ Elbow Pain | ▫ Ulcers | ▫ Urinary Difficulties | ▫ Other:_____ |

## III. Hospitalization, Surgeries and Injuries

Do you have a pacemaker? ▫ yes ▫ no

Have you had a knee, hip, or shoulder replacement surgery? ▫ yes ▫ no

Do you have any other implantable medical device in your body? ▫ yes ▫ no

Please list any hospitalization, surgeries, or injuries that you have had (if none, write NONE):

| | Date | Description |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

## IV. Medications and Supplements

Are medications (prescription or over-the-counter) necessary for you to have relief and/or to function? ▫ yes ▫ no

Please list any supplements and/or medications (RX and OTC) you are currently taking and why (if none, write NONE):

1_____ 5_____

2_____ 6_____

3_____ 7_____

4_____ 8_____

## V. Genetic History

Have any of your blood relatives had any of the following conditions? If yes, please list who (if none, write NONE).

Heart Disease_____ Stroke_____

Cancer_____ Arthritis_____

Diabetes_____ Auto-Immune Disease_____

What types of care are you seeking? (mark all that apply)

▫ Injury Prevention ▫Nutritional and supplement counseling ▫ Health education classes

▫ Balance & Coordination training ▫ Spinal and Body Alignment ▫ Treatment for Pain

▫ Range of motion, mobility or flexibility training ▫ Strengthening/stamina ▫ Other_____