PATIENT REGISTRATION

PATIENT INFORMATION

Date_____ File # _____

Patient Name_____

Address_____

City_____

State_____ Zip_____

Sex: ☐ Male ☐ Female SS#:_____

Birthdate:_____ Age_____

Name of family physician_____

May we contact them regarding your health? ☐ Yes ☐ No

Would you like to electronically access to your health records? ☐ Yes ☐ No

CONTACT INFORMATION

Parent or Guardian _____

Relationship _____ Phone _____

ACCIDENT INFORMATION

Injury due to an accident? ☐ Yes ☐ No

If yes, Date of accident _____

Type of accident ☐ Auto ☐ Home ☐ Other _____

Have you made a report of your accident? ☐ Yes ☐ No

To Whom? ☐ Auto Insurance ☐ Other _____

Attorney Name (if applicable)_____

ELECTRONIC HEALTH RECORD REPORTING (Per Federal Requirements)

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Two or more

Preferred language: ☐ English ☐ Spanish ☐ French ☐ German ☐ Italian ☐ Mandarin ☐ Cantonese ☐ Japanese ☐ Tagalog ☐ Other _____

Preferred contact method: ☐ Call cell ☐ Text cell ☐ Call home ☐ Call work ☐ Email ☐ Fax (_____)

PATIENT CONDITION (HPI)

Reason for visit:_____

When did symptoms start? _____ How did problem start? _____

If you have pain, rate your pain level (circle one):

0 1 2 3 4 5 6 7 8 9 10

No Pain ***Severe Pain***

Is your pain: ☐ Constant **(100% of day)** ☐ Frequent **(75% of day)** ☐ Occasional **(50% of day)** ☐ Intermittent **(25% of day)**

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS *please check ☑ any that apply to you*

Constitutional
- ☐ Bad general health
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches

Eyes
- ☐ Eye disease/injury
- ☐ Glasses or contact lens
- ☐ Blurred / double vision

Ear, Nose, Throat
- ☐ Hard of Hearing
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Sore throat / voice change
- ☐ Swollen glands

Musculoskeletal
- ☐ Joint Pain / Stiffness
- ☐ Joint Swelling
- ☐ Chronic fatigue
- ☐ Fibromyalgia

Cardiovascular
- ☐ Chest pain / Palpitations
- ☐ Dizziness / Fainting
- ☐ Shortness of breath
- ☐ Swelling in hands / feet
- ☐ High blood pressure
- ☐ High cholesterol

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Diarrhea/Constipation

Neurological
- ☐ Seizures or Epilepsy
- ☐ Numbness / Tingling

Genito-urinary
- ☐ Pain / Difficulty urinating
- ☐ Kidney stones
- ☐ Kidney problems

Respiratory
- ☐ Cough
- ☐ Congestion
- ☐ Wheezing / Asthma
- ☐ Pneumonia

Psychiatric
- ☐ Anxiety / Depression
- ☐ Mood Swings
- ☐ Difficulty sleeping
- ☐ ADHD

Integumentary (skin, breast)
- ☐ Rash / Sores
- ☐ Lesions
- ☐ Dermatitis / Eczema

Hematologic/Lymphatic
- ☐ Slow to heal after cuts
- ☐ Bleed or bruise easily
- ☐ Anemia
- ☐ Enlarged glands

Endocrine
- ☐ Excessive thirst / urination
- ☐ Heat or cold intolerance
- ☐ Skin becoming drier
- ☐ Diabetes
- ☐ Thyroid disorder

Allergic/Immunologic
- ☐ Food allergies
- ☐ Airborne allergies
- ☐ Systemic Lupus

If 14 or over: Tobacco Use
- ☐ Yes
- ☐ No

PATIENT NAME: **FILE #:**

FAMILY HISTORY

	Living?		Rheum Arthritis		Heart Problems		Diabetes		Asthma		Cancer		Back Problems	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brothers/Sisters	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

HOSPITALIZATIONS AND SURGERIES

Fractures _____ Hospitalizations_____

Surgeries_____

PRESCRIBED MEDICATIONS

Name of drug	Quantity	Strength (10 mg, 25 mg, etc.)	Dose form (tablet, aerosol, etc.)	Instructions (1/day, etc)

Are you allergic to any medications? ☐ No ☐ Yes (if yes, list name and symptoms) _____

_____

List any vitamins or supplements you take _____

__

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the clinic any changes in my medical status.

_____ _____ **Reviewed by:**_____

Signature of Parent or Guardian of Minor **Date**

CONSENT TO TREATMENT OF MINOR CHILD

Estadt Lemire Chiropractic Center
9031 Mentor Avenue
Mentor, OH 44060
(440) 255-1315

I hereby authorize Dr. Lemire and whomever he may designate as assistants to administer chiropractic care as deemed necessary to my _____ (indicate relationship to child), _____.
(Name of Child)

Dated at _____ in _____, _____ this _____ day of _____, 20_____.
(Time) (City) (State)

Signed: _____
(Parent/Guardian)

Witness: _____