NEW PATIENT REGISTRATION

Today's Date:_____/_____/__________

Welcome to Arena Chiropractic! Your Health History is important to us.

Please follow the instructions throughout the form and provide us with as much information about yourself as possible.

Are you the patient or are you completing this for the patient?

❑ I am the patient ❑ I am completing this for the patient Name ____________________________________

Is the patient a minor ❑ Yes ❑ No

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_______________________________________

Last Name _______________________________________ Middle Name _____________________Suffix ___________

Address 1 ____

Address 2 ____

City____ State______________ Zip Code _______________________

Primary Phone _____________________________________**Secondary Phone** ____________________________________

Primary Email ___________________________________

Date of Birth: _____/_____/___________ **Age** ________ **Gender** ***(check one)*** ❑ Male ❑ Female

Marital Status ***(check one)*** ❑ Single ❑ Married ❑ Other

Race ***(check one)***

❑ White ❑ Black/African American ❑ American Indian/Alaskan Native ❑ Asian

❑ Native Hawaiian or other Pacific Island ❑ Other____________________ ❑ I choose not to specify

Ethnicity ***(check one)*** ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language ***(check one)***

❑ English ❑ Spanish ❑ Chinese ❑ French ❑ Tagalog ❑ American Sign Language

❑ Other_____________________________ ❑ I choose not to specify

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Employer Name ___________________________________ Address ____

City____ State______________ Zip Code _______________________

Phone ____ Job Description ____________________________________

Insurance Information

Subscriber's Name: ______________________________ Date of Birth _____/______/_________

Relationship to patient: _______________________________________

Insurance Co.: _______________________________________ Policy #: ______________________

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name: ______________________________ Date of Birth _____/______/_________

Relationship to patient: _______________________________________

Insurance Co.: _______________________________________ Policy #: ______________________

Please list current medications (prescription, over-the-counter and supplements) including frequency and dosage if known. **If there are no current medications, check here:** ❑

1) ____ 5) ____

2) ____ 6) ____

3) ____ 7) ____

4) ____ 8) ____

List any known allergies you have had to any medications.

If no allergies are known, check here: ❑

1) ____ 3) ____

2) ____ 4) ____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

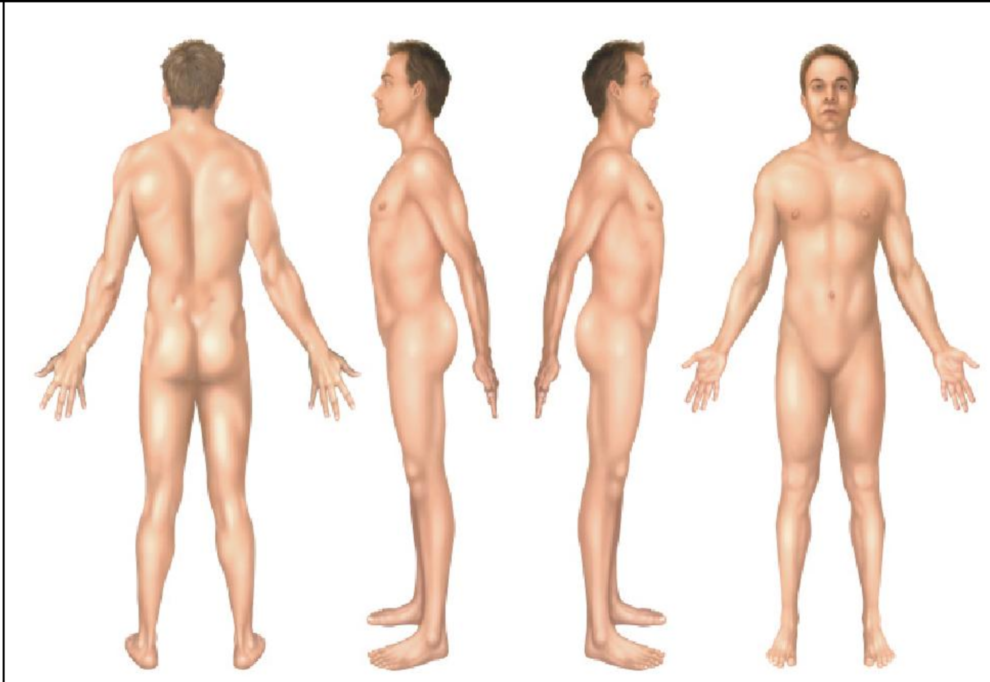
Has any doctor diagnosed you with Hypertension presently? ❑ Yes ❑ No

If yes, describe: ____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

= Numbness   X = Burning   / = Stabbing   0 = Pins & Needles   + = Dull Ache   P = Pain



Describe your symptoms:____

When did your symptoms start? Month_____ Day_____ Year___________

How did your symptoms begin?____

Indicate the intensity of your symptoms 0 --- 10

No Pain   Worst Pain

Prior interventions- What have you done to relieve the symptoms?

- ❑ Prescription medication
- ❑ Acupuncture
- ❑ Over the counter medication
- ❑ Ice
- ❑ Homeopathic remedies
- ❑ Heat
- ❑ Physical therapy
- ❑ Chiropractic
- ❑ Massage
- ❑ Other ____________________________________

Is your condition due to an accident? ❑ Yes ❑ No Date _______________

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other _____________________

To whom have you reported your accident?

❑ Auto Insurance ❑ Employer ❑ Workers Comp. ❑ Other ________________________

Attorney Name (if applicable) ____

Is there anything else we should know about your current condition? ____

____

Musculoskeletal ❑ No Issues

Osteoporosis	Arthritis	Scoliosis	Neck Pain
❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No
Back Problems	Hip disorders	Knee injuries	Foot/ankle pain
❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No
Shoulder problems	Elbow/wrist pain	TMJ issues	Poor posture
❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No

Neurological ❑ No Issues

Anxiety	Depression	Headache	Dizziness
❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No
Pins and needles	Numbness		
❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No		

Cardiovascular ❑ No Issues

High blood pressure	Low blood pressure	High cholesterol	Poor circulation
❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No
Angina	Excessive bruising		
❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No		

Respiratory ❑ No Issues

Asthma	Apnea	Emphysema	Hay fever
❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No
Shortness of breath	Pneumonia		
❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No		

Digestive ❑ No Issues

Anorexia/bulimia	Ulcer	Food sensitivities	Heartburn
❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No
Constipation	Diarrhea		
❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No		

Sensory ❑ No Issues

Blurred vision	Ringing in ears	Hearing loss	Loss of smell
❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No
Loss of taste	Chronic ear infection		
❑ Have ❑ Had ❑ No	❑ Have ❑ Had ❑ No		

Integumentary ❑ No Issues

Skin cancer
❑ Have ❑ Had ❑ No

Psoriasis
❑ Have ❑ Had ❑ No

Eczema
❑ Have ❑ Had ❑ No

Acne
❑ Have ❑ Had ❑ No

Hair loss
❑ Have ❑ Had ❑ No

Rash
❑ Have ❑ Had ❑ No

Endocrine ❑ No Issues

Thyroid issues
❑ Have ❑ Had ❑ No

Immune disorders
❑ Have ❑ Had ❑ No

Hypoglycemia
❑ Have ❑ Had ❑ No

Frequent infection
❑ Have ❑ Had ❑ No

Swollen glands
❑ Have ❑ Had ❑ No

Low energy
❑ Have ❑ Had ❑ No

Genitourinary ❑ No Issues

Kidney stones
❑ Have ❑ Had ❑ No

Infertility
❑ Have ❑ Had ❑ No

Bedwetting
❑ Have ❑ Had ❑ No

Prostate issues
❑ Have ❑ Had ❑ No

Erectile dysfunction
❑ Have ❑ Had ❑ No

PMS symptoms
❑ Have ❑ Had ❑ No

Constitutional ❑ No Issues

Fainting
❑ Have ❑ Had ❑ No

Low libido
❑ Have ❑ Had ❑ No

Poor appetite
❑ Have ❑ Had ❑ No

Fatigue
❑ Have ❑ Had ❑ No

Sudden weight gain/loss
❑ Have ❑ Had ❑ No

Weakness
❑ Have ❑ Had ❑ No

Have you ever had surgery? ❑ Yes ❑ No If yes, please list reason and date ___________________________________

____

Please list any previous injuries____

____

Family History

Relative	Health Condition/Illness
Mother	
Father	
Brother(s)	
Sister(s)	
Son(s)	
Daughter(s)	

What are your typical eating habits?

❑ Skip Breakfast ❑ 2 meals a day ❑ 3 meals a day ❑ Snacking between meals

Privacy Verification

❑ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Permission to Contact

❑ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Payment Verification

❑ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

General Verification

❑ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature of Patient ______________________________________