Diamond Chiropractic And Physical Medicine

5133 West 140th Street
Brook Park Ohio, 44142

NEW PATIENT REGISTRATION

Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State:_____ ZIP Code: _____

Phone Number: _____ □ Cell □ Home □ Work

E-Mail Address: _____

How did you hear about us? _____

Marital Status: □ Single □ Married □ Other Gender: _____

Smoking History: □ Current Smoker □ Previous Smoker □ Never Smoked

INSURANCE INFORMATION

Insurance Company: _____ Date of Birth of Insured_____

Relationship to Insured: □ Self □ Spouse □ Child □ Other:_____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone Number: _____

EMPLOYMENT INFORMATION

□ Employed □ Self Employed □ Student □ Retired □ Other

Employer Name: _____ Job Title: _____

Address: _____

City: _____ State:_____ ZIP Code: _____

History of Treatment

Primary care physician: _____ Phone: _____

Date last seen: _____ May we update them on your condition? ____Yes _____ No

Have you seen a chiropractor before? _____

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider:

_____

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For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
○	○	Abdominal Pain	○	○	Elbow/upper arm pain	○	○	Liver/Gall Bladder Disorder
○	○	Abnormal Weight gain/loss	○	○	Epilepsy	○	○	Loss of Bladder Control
○	○	Allergies Headache	○	○	Excessive thirst	○	○	Low back pain
○	○	Angina	○	○	Frequent Urination	○	○	Mid back pain
○	○	Ankle/foot pain	○	○	General Fatigue	○	○	Neck pain
○	○	Arthritis	○	○	Hand pain	○	○	Painful Urination
○	○	Asthma	○	○	Heart attack	○	○	Prostate Problems
○	○	Bladder Infection	○	○	Hepatitis	○	○	Shoulder pain
○	○	Birth Control Pills	○	○	High blood pressure	○	○	Smoking/tobacco Use
○	○	Cancer	○	○	Hip/upper leg pain	○	○	Stroke
○	○	Chest Pains	○	○	HIV/AIDS	○	○	Systematic Lupus
○	○	Chronic Sinusitis	○	○	Hormone Therapy	○	○	Thoracic Outlet Syndrome
○	○	Depression	○	○	Jaw pain	○	○	Tumor
○	○	Dermatitis/Eczema	○	○	Joint swelling/stiffness	○	○	Ulcer
○	○	Dizziness	○	○	Kidney Stones	○	○	Upper back pain
○	○	Drug/Alcohol Use	○	○	Knee/lower leg pain	○	○	Wrist pain

Past Medical History

Allergies: _____

Past Surgical History: _____

Medications: _____

Family Health History: _____

Additional comments you would like the doctor to know:

_____

_____

_____

Signature of Patient Printed Name Date

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CHIEF COMPLAINT

□ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain

□ Other _____

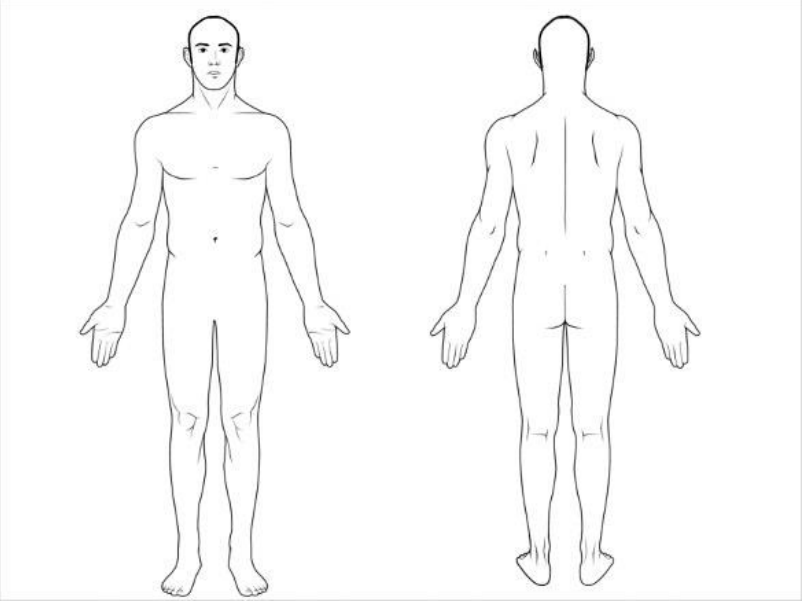
Is this condition due to an accident? □ Yes □ No Date of Accident: _____

What kind of accident? □ Auto □ Work □ Home □ Sports □ Other

CURRENT HEALTH CONDITION

Please use the body diagram to describe your pain

XXX Sharp Pain *** Pins/Needles +++ Dull Ache ### Numbness ^^^ Burning /// Stabbing



Describe Your Chief Complaint

Please rate your pain on a scale from 0 – 10 (if multiple areas of complaint, indicate each area)

No Pain **0** - 1- 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - **10** Worst Pain/Emergency Room

How often: □ 0 – 25% □ 25 – 50% □ 50 – 75% □ 75 – 100% □ 100%

When were you first aware of this problem: _____

How did this condition develop? _____

This condition is: □ Getting Worse □ Getting Better □ Staying the Same

What makes this condition ***worse***: □ Sitting □ Standing □ Lifting □ Bending □ Driving

□ Sleeping □ Working on Computer/Phone □ Walking □ Driving □ Sneezing/Coughing

What makes this condition ***better***: □ Rest □ Medication □ Ice/Heat □ Stretching □ Nothing

Are you able to sleep? □ Yes □ No Are you able to work? □ Yes □ No

Are you pregnant? □ Yes, how many weeks? _____ □ No

Patient's Signature: _____ Date: _____