Carlson Wellness Clinic
chiropractic & massage

PATIENT REGISTRATION AND HEALTH QUESTIONNAIRE

Today's Date_____

Patient Information

Name _____
Last

_____
First Middle Initial

Address_____
City _____
State_____Zip_____
Home # _____
Cell# _____
Email _____
Gender: ◯Male ◯Female
Birth Date _____
Marital Status: ◯M ◯S ◯D ◯W
Names and Ages of Children

_____
_____
_____

Employer_____
Ocupation _____
Work Phone # _____

Name of Spouse_____
Employer _____
Occupation _____
Work Phone #_____

Emergency Contact Person

_____
Phone # _____

How did you hear about Carlson Wellness Clinic?

_____
Have you ever been under chiropractic care?
◯Yes ◯No
Dr.'s Name_____

Patient Insurance

Insurance Co._____
Policy Holder_____
Relationship to patient_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____
Name of insurance company

And assign directly to Dr. Benjamin Carlson, Dr. Jessi Phillips, and/or Dr. Susan Herda all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____
Signature of patient, parent, guardian or person representative

_____
Please print name of patient, parent, guardian or person representative

_____ _____
Date Relationship to patient

PAYMENTS ARE DUE AT TIME OF VISIT. THANK YOU.

Health History

Primary reason for visit: _____
_____
_____

When did your symptoms begin?
_____

What was the cause, if known?
_____
_____
_____

How often do you experience your symptoms?
- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

What describes the nature of your symptoms:

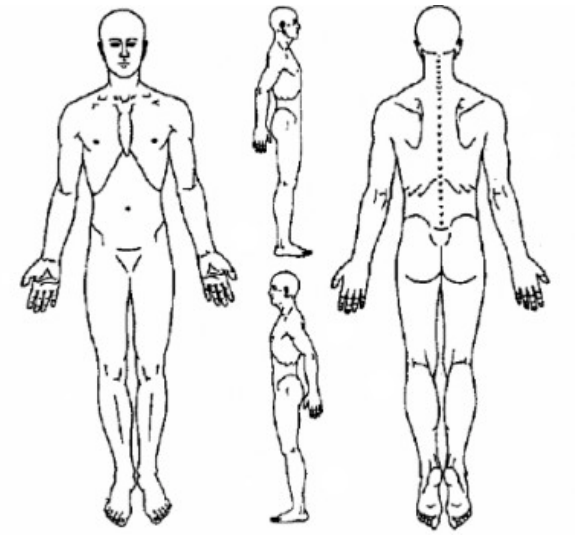
Sharp	Throbbing	Dull ache
Cramping	Shooting	Stiffness
Burning	Swelling	Tingling
Radiating	Numbness	Inflamed

Other_____

Please rate your pain on a scale of 0-10
(0=No pain, 10=Worst Pain Possible)

1	2	3	4	5
6	7	8	9	10

On the picture below, mark an X on all areas where any symptoms occur.



How are your symptoms changing?
Getting better
Not changing
Getting worse

Describe how you feel when the problem is at its worst:
_____
_____
_____

To what degree do your symptoms affect your ability to perform daily activities?
Not at all
Mildly (forgotten with activity)
Moderately (interferes with activity)
Limiting (prevents full activity)
Intensely (focused on seeking relief)
Severely (no activity possible)

Activities or movements that are painful to perform include:

Sitting	Twisting	Bending
Lying Down	Walking	Standing

Symptoms cause interference with:

Work	Recreation
Sleep	Daily Routine

What makes your symptoms worse?
_____
_____
_____

What makes your symptoms better?
_____
_____
_____

Have you had similar symptoms in the past?
Yes No If yes, when? _____

Name of other doctors (please include clinic name) you have seen for these symptoms:_____
_____
_____
_____

What treatment was given? When?
Medication (date)_____
Surgery (date) _____
Physical therapy (date)_____

What does your work activity consist of?
Sitting Standing
Light Labor Heavy Labor

What type of exercise do you perform?
None Moderate
Light Strenuous
# of days per week: _____

Are you currently pregnant?
Yes No Maybe
If yes, due date: _____

List of all serious illnesses, injuries (including falls, broken bones and dislocations) and surgeries:

_____
_____
_____

List all prescriptions and over the counter medications you are currently taking and why:

_____
_____
_____
_____

List all nutritional/herbal supplements you are currently taking and why:

_____
_____
_____
_____

List any allergies you have:

_____
_____
_____

Smoking status (age 13 and over):
Current every day smoker
Current some day smoker
Former smoker
Never smoked

Fill in the numbers that apply:
Water: _____Glasses/Day
Tobacco: _____Packs/Day
Alcohol: _____Drinks/Week
Coffee: _____Cups/Day
Pop w. Caffeine: _____Cans/Day
Stress Level: _____
(1) Low (2) Moderate (3) High (4) Very High

Please list any other symptoms or health concerns you may have:

_____
_____
_____
_____
_____

Additional Information

Preferred Language
English Other: _____

Race/Ethnicity: _____

Vitals (taken in office)

Height: _____in.
Weight: _____lbs.

Blood Pressure _____/_____

Additional Notes

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

→ Continue to next page

Place a mark in the ***past*** column if you have had the condition in the past. If you presently have the condition, place a mark in the **present** column. Some conditions may require that you mark both.

Past	***Present***	
O	O	Headaches
O	O	Migraine
O	O	Jaw Pain
O	O	Neck Pain
O	O	Shoulder Pain
O	O	Back Pain
O	O	Elbow Pain
O	O	Wrist Pain
O	O	Hip Pain
O	O	Knee Pain
O	O	Ankle Pain
O	O	Muscle Pain
O	O	Joint Pain
O	O	Joint Stiffness
O	O	Pinched Nerve
O	O	Herniated Disc
O	O	Abdominal Pain
O	O	Diarrhea/Constipation
O	O	Excessive Thirst
O	O	Frequent Nausea/Vomiting
O	O	Gallstones
O	O	Heartburn
O	O	Hepatitis
O	O	Liver/Gall Bladder disorder
O	O	Loss of Appetite
O	O	Loss of Bladder/Bowel Control
O	O	Ulcer
O	O	Unintentional Weight gain/loss
O	O	Allergies
O	O	Sinus Trouble
O	O	Asthma
O	O	Bronchitis
O	O	Hay Fever
O	O	Shortness of Breath
O	O	Bleeding Disorder
O	O	Blood Disease
O	O	Chest Pain
O	O	Heart Attack
O	O	Heart Trouble

Past	***Present***	
O	O	High Blood Pressure
O	O	Low Blood Pressure
O	O	Stroke
O	O	Use of Pacemaker
O	O	Bladder Infection
O	O	Bladder Trouble
O	O	Frequent Urination
O	O	Kidney Disorder
O	O	Kidney Infection
O	O	Kidney Stones
O	O	Painful Urination
O	O	Skin Troubles
O	O	Menopause
O	O	Menstrual Trouble
O	O	Miscarriage
O	O	Pregnancy
O	O	Prostate Trouble
O	O	Sexual Problems
O	O	Use of Birth Control
O	O	Use of Hormone Replacement
O	O	Anorexia/Bulimia
O	O	Depression
O	O	Dizziness
O	O	Drug/Alcohol Dependency
O	O	Excessive Fatigue
O	O	Troubled Sleep
O	O	Use of Psychiatric Care
O	O	Awakened by Pain at night
O	O	Cancer
O	O	Fever, Chills, Sweats
O	O	Gout
O	O	HIV/AIDS
O	O	Immune Systems Abnormality
O	O	Infection
O	O	Multiple Sclerosis
O	O	Osteoporosis
O	O	Rheumatoid Arthritis
O	O	Thyroid Problems
O	O	Tumor
O	O	Use of Corticosteroids