ADVANCED CHIROPRACTIC CENTER

6035 Greenback Ln. Citrus Heights, CA 95621

• Ph (916) 580-3277 •Fax (916) 307-5166

NEW PATIENT REGISTRATION

Today's Date___________________

Name____
Last First Middle

(Complete Mailing)
Address____
Street Apt# City State Zip

Social Security # ________ – ______ – ________ Date of Birth__________________

Home Phone # (_____)______–_______ Work Phone # (_____)______–_______

Cell Phone # (_____)______–_______ E-mail Address: ___________________________________

Emergency Contact___________________ Relationship____________ Phone# (_____)______–_____

Employer_______________________ Occupation_________________ Phone# (_____)______–______

Is this visit routine/accident/illness/other: _________________ If Accident (date) ________________

RESPONSIBLE PARTY INFORMATION

Name (Guarantor)____
Last First Middle

Relationship to Patient ____________________________

Address ____
Street City State Zip

Employer___________________________

Address____ Phone #(_____)______–_______

Name of Insurance______________________ ID#______________________Grp#_______________

(please complete other side)

Please notify our front office staff if there is an alternate address / phone number or form of communication that you wish us to contact you by other than your listed information above.

I have read and understand that this alternative is available to me

______________________________ ______________________________
Signature Date

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PERSONAL HEALTH HISTORY

Patient's Name ____ **DOB** _______________ **Date** _____________

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

Describe Your Problem: (where does it hurt or why are you here)____

____

Please answer the following questions	Doctor's Notes Below
How long have you had the condition:	
Is it getting: ☐Better ☐Worse ☐Staying the same	
What seemed to be the cause: ____________________ ____	
Does it: hurt all the time ☐ or does it come and go ☐	
Can you rate it on a scale of 1-10, with 0 being no pain at all, and 10 being the worst pain imaginable: ________	
Describe what the pain feels like? (i.e. sharp, dull, achy)	
Are there patterns: (i.e. better in the morning, worse at end of the day) _________________________________ ____	
Does anything make it better? (i.e. ice, medications) ____ ____	
Does anything make it worse? (i.e. sitting, standing) ____ ____	
Is there any (circle all that apply) numbness, tingling, weakness, nausea, vomiting, dizziness, bowel or bladder changes	

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Have you received any other medical treatment for this condition? if so: Where ____ What did they do? _____________________________ ____ ____ ____	
What were the results of treatment? _____________ ____ ____ ____	
Have you been hospitalized in the past 5 years: ☐ Yes ☐ No	
List any serious illnesses you have had: ____________ ____ ____	
List any surgeries you have had: __________________ ____ ____	
List any current medications: _____________________ ____ ____ ____	
List any allergies you have: ______________________ ____ ____	

Doctor's Use Only
____ ____ ____ ____

ACTIVITIES OF DAILY LIVING (ADL) WORKSHEET

Name____________________________________**Date:**____________________

*(Please **circle the number** which most closely describes your "Activities Of Daily Living" today)*

1. Pain Intensity

(0)	(1)	(2)	(3)	(4)
No Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Possible Pain

2. Frequency Of Pain

(0)	(1)	(2)	(3)	(4)
No Pain	Occasional Pain 25% Of The Day	Intermittent Pain 50% Of The Day	Frequent Pain 75% Of The Day	Constant Pain 100% Of The Day

3. Personal Care (Washing, Dressing, etc.)

(0)	(1)	(2)	(3)	(4)
Restrictions	No Restrictions	Need to go slowly	Need some assistance	Need 100% Assistance

4. Travel (Driving, Riding, etc.)

(0)	(1)	(2)	(3)	(4)
No Pain On Long Trips	Mild Pain On Long Trips	Moderate Pain On Long Trips	Moderate Pain On Short Trips	Severe Pain On Short Trips

5. Work

(0)	(1)	(2)	(3)	(4)
Can Do Usual Work Plus Extra Work	Can Do Usual Work No Extra Work	Can Do 50% Of Usual Work	Can Do 25% Of Usual Work	Cannot Work

6. Recreation

(0)	(1)	(2)	(3)	(4)
Can Do All Activities	Can Do Most Activities	Can Do Some Activities	Can Do A Few Activities	Cannot Do Any Activities

7. Sleeping

(0)	(1)	(2)	(3)	(4)
Perfect Sleep	Mildly Disturbed	Moderately Disturbed	Greatly Disturbed	Totally Disturbed

8. Lifting

(0)	(1)	(2)	(3)	(4)
No Pain With Heavy Weight	Increased Pain With Heavy Weight	Increased Pain With Moderate Weight	Increased Pain With Light Weight	Increased Pain With Any Weight

9. Walking

(0)	(1)	(2)	(3)	(4)
No Pain Any distance	Increased Pain After One Mile	Increased Pain After Half Mile	Increased Pain After Quarter Mile	Increased Pain With All Walking

10. Standing

(0)	(1)	(2)	(3)	(4)
No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After One Hour	Increased Pain After Half Hour	Increased Pain With Any Standing