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Welcome to Active Edge Chiropractic where our mission is to provide each of our patients with a personalized health care experience. By utilizing a multidisciplinary treatment approach, we create individualized programs to help your body heal, thrive, and meet the demands of your busy life. We are excited for the opportunity to help you reach your optimal function and health.

Patient Registration Form

Name _____ Male Female

Address _____ Apt # _____

City _____ State _____ Zip _____

Social Security # _____

Email Address _____ Date of Birth _____ Age _____

Primary Phone _____ Cell Home Cell Home
Secondary Phone _____ Home

Cell Provider _____ How would prefer to receive appointment reminders Email Text

May we leave messages at home with other residents? **Y / N**

May we leave personal health information on your answering machine/voicemail? **Y / N**

May we contact you via e-mail or cellular phone? **Y / N**

Occupation: _____ Employer: _____

Marital Status: single married domestic partner divorced widowed

Present MD _____ would you like notes sent? **Y/N**

Emergency Contact:

Name _____

Relationship _____ Phone #1 _____ Phone #2 _____

How did you hear about us? _____

Signature _____ Date _____

New Patient/ New Injury Physical Symptom Report

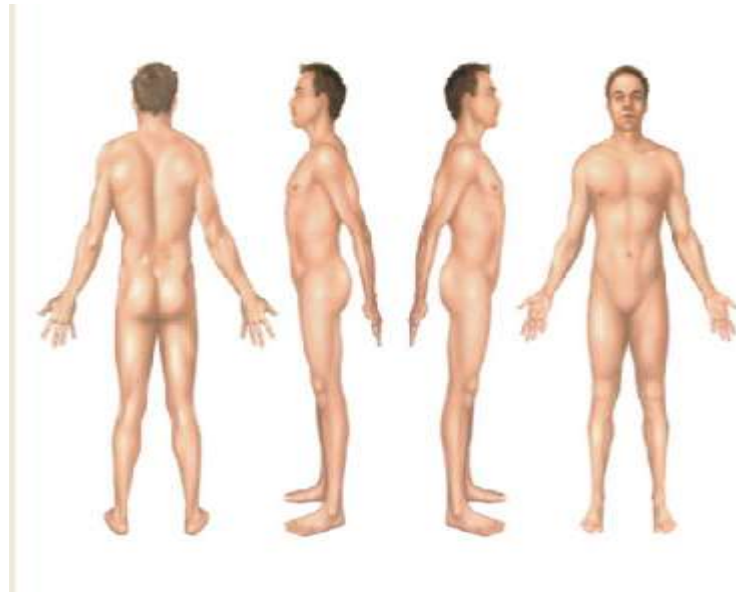
Patient Name: _____
Please Print

Pt. #: _____

Patient Signature: _____

Date: _____

Indicate problem areas with circle or X on diagram below. Please Grade your pain on a scale of 0-10. [0= No Pain, 10= Extreme Pain] Choose how Frequent the pain is present and indicate approximately when problem began



Neck: 0 1 2 3 4 5 6 7 8 9 10
 Seldom-Intermittent-Frequent-Constant
 When did symptom begin? _____

Upper/Mid Back: 0 1 2 3 4 5 6 7 8 9 10
 Seldom-Intermittent-Frequent - Constant
 When did symptoms begin? _____

Lower Back: 0 1 2 3 4 5 6 7 8 9 10
 Seldom-Intermittent-Frequent-Constant
 When did symptoms begin? _____

Other: _____ 0 1 2 3 4 5 6 7 8 9 10
 Seldom - Intermittent - Frequent - Constant
 When did symptoms begin? _____

Briefly describe your symptoms:

List any other medical professionals you have seen or consulted for these problems and indicate whether treatment was helpful or not.

What, if any, imaging you have received for this condition?

Circle which ones describe your symptoms and indicate complaint being referenced:

- | | | | |
|--|-----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> dull | <input type="checkbox"/> burning | <input type="checkbox"/> stabbing | <input type="checkbox"/> radiating |
| <input type="checkbox"/> sharp | <input type="checkbox"/> deep | <input type="checkbox"/> cramping | <input type="checkbox"/> shooting |
| <input type="checkbox"/> sharp with movement | <input type="checkbox"/> aching | <input type="checkbox"/> pinprick | <input type="checkbox"/> stiffness |
| <input type="checkbox"/> throbbing | <input type="checkbox"/> tingling | <input type="checkbox"/> numbness | |

Circle activities or items that relieve your condition:

- | | | | |
|-----------------------------------|--|--------------------------------------|---|
| <input type="checkbox"/> sitting | <input type="checkbox"/> leaning for support | <input type="checkbox"/> ice | <input type="checkbox"/> rest |
| <input type="checkbox"/> standing | <input type="checkbox"/> not moving | <input type="checkbox"/> topical gel | <input type="checkbox"/> stretching/ exercise |

- lying down
- movement
- ibuprofen
- adjustment
- knees bent
- heat
- prescribed medication

Circle the activities that aggravate your condition(s):

- | | | | |
|---|-----------------------------------|------------------------------------|--|
| <input type="checkbox"/> sitting | <input type="checkbox"/> stooping | <input type="checkbox"/> coughing | <input type="checkbox"/> looking up |
| <input type="checkbox"/> lying face up | <input type="checkbox"/> chores | <input type="checkbox"/> carrying | <input type="checkbox"/> opening jars |
| <input type="checkbox"/> standing | <input type="checkbox"/> lifting | <input type="checkbox"/> straining | <input type="checkbox"/> look down |
| <input type="checkbox"/> driving | <input type="checkbox"/> exercise | <input type="checkbox"/> pulling | <input type="checkbox"/> reading |
| <input type="checkbox"/> recreation | <input type="checkbox"/> walking | <input type="checkbox"/> sleeping | <input type="checkbox"/> reaching |
| <input type="checkbox"/> movement | <input type="checkbox"/> typing | <input type="checkbox"/> stairs | <input type="checkbox"/> running |
| <input type="checkbox"/> picking up objects | <input type="checkbox"/> bending | <input type="checkbox"/> sneezing | <input type="checkbox"/> twisting |
| <input type="checkbox"/> rest / sleeping | <input type="checkbox"/> scooping | <input type="checkbox"/> shopping | <input type="checkbox"/> sit to stand |
| <input type="checkbox"/> reaching behind | <input type="checkbox"/> throwing | <input type="checkbox"/> writing | <input type="checkbox"/> sports activities |

Would you like improvement with any of the following?:

- | | |
|--|--|
| <input type="checkbox"/> Digestion: Reflux, Gas, Constipation | <input type="checkbox"/> Skin: Rash, dryness, acne, eczema |
| <input type="checkbox"/> Weight: loss, distribution, management | <input type="checkbox"/> Sleep: Falling asleep or staying asleep |
| <input type="checkbox"/> Sense of Well Being | <input type="checkbox"/> Hormones: sex drive, mood swings, PMS, fertility |
| <input type="checkbox"/> Energy Levels, Brain Fog, Fatigue | <input type="checkbox"/> Other: _____ |

----- **For staff use (below)** -----

Height: _____ **Weight:** _____ **BP:** _____ **Pulse:** _____

Personal Health History

Name: _____

Date: _____

Please check that apply

Past	Present	Condition
		Neck Pain
		Shoulder Pain
		Pain in Upper Arm or Elbow
		Hand Pain
		Wrist Pain
		Upper Back Pain
		Low Back Pain
		Pain in Upper Leg or Hip
		Pain in Lower Leg or Knee
		Pain in Ankle or Foot
		Jaw Pain
		Swelling/Stiffness of Joint(s)
		Fainting
		Visual Disturbance
		Convulsions
		Dizziness
		Headache
		Muscular Incoordination
		Tinnitus (Ear Noises)
		Asthma
		Allergies
		Dermatitis/Eczemas/Rash
		Bedwetting
		Colic
		ADHD
		Depression/Emotional Issues
		Anxiety
		Other mood disorder: _____
		Rapid Heart Beat
		Chest Pains
		Aortic Aneurysm
		High Blood Pressure
		Heart Attack
		Stroke
		Cancer
		Tumor
		Hepatitis
		HIV/AIDS
		Other Blood Disorder: _____

Past	Present	Condition
		Loss of Appetite
		Anorexia
		Abnormal Weight _____ Loss Gain
		Excessive Thirst
		Chronic Cough
		Chronic Sinusitis
		General Fatigue
		Irregular Menstrual Flow
		Profuse Menstrual Flow
		Breast Soreness/Lumps
		Endometriosis
		PMS
		Pregnancy: number of children: _____
		Birth Control
		Hormone/Estrogen Replacement
		Loss of Bladder Control
		Prostate Problems
		Painful Urination
		Frequent Urination
		Bladder Infection
		Kidney Stones
		Other Kidney Disorders:
		Liver/Gallbladder Pain/Disorder
		Abdominal Pain
		Constipation/Irregular Bowel Habits
		Colitis/Crohnes (circle)
		IBS (irritable bowel syndrome)
		Ulcer
		Difficulty Swallowing
		Heartburn/Indigestion
		Epilepsy
		Emphysema (Chronic Lung Disorders)
		Arthritis
		Rheumatoid Arthritis
		Diabetes
		Systemic Lupis
		Other Autoimmune Disorders: _____
		Other: _____

Medications (list): _____

Hospitalizations or Surgeries: _____

Family Health History

Patient Name: _____

Date: _____

Please review the conditions listed below and indicate those that are current health problems of a family member by the designation C under his or her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Children		
	Age	Age	Age	Age	Age	Age
Allergies						
Anxiety						
Asthma						
ADHD						
Back trouble						
Bed wetting						
Cancer						
Colic						
Constipation						
Depression						
Diabetes						
Disc problems						
Ear infections						
Emotional issues						
Emphysema						
Epilepsy						
Headaches						
Heart trouble						
Heart burn						
High blood pressure						
IBS						
Indigestion						
Infertility						
Insomnia						
Kidney trouble						
Neck pain						
Nervousness						
Obesity						
Pinched nerve						
Scoliosis						
Sinus trouble						
Other						

Additional Comments: _____
