Jasmine Craner D.C., C.S.C.S
Erik Hensel D.C.
1156 Dublin Rd. Suite 102
Columbus, OH 43215
(614) 407-5335

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 Secondary Phone _____ □ Cell □ 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? _____

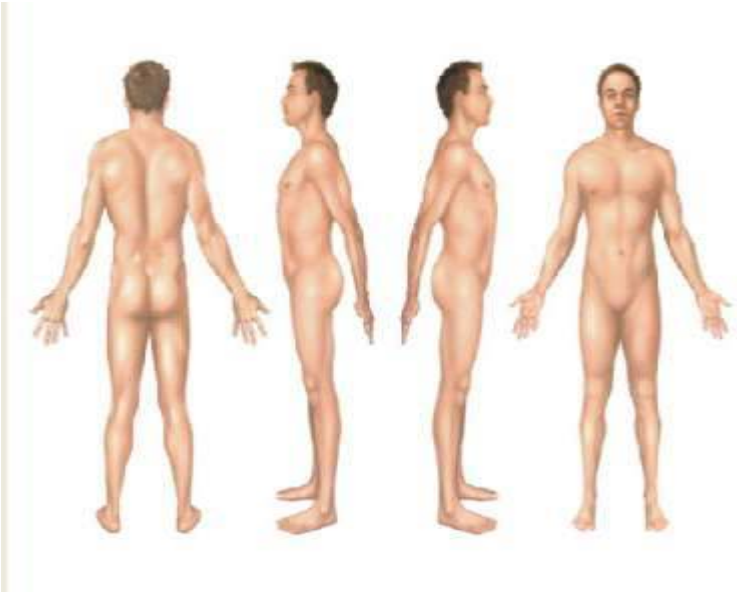
Signature _____ **Date** _____

New Patient/ New Injury Physical Symptom Report

Patient Name: _____ **Pt. #:**_____
Please Print

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 were helpful or not.

_____

_____

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

_____

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

☐ dull	☐ burning	☐ stabbing	☐ radiating
☐ sharp	☐ deep	☐ cramping	☐ shooting
☐ sharp with movement	☐ aching	☐ pinprick	☐ stiffness
☐ throbbing	☐ tingling	☐ numbness	

Circle activities or items that relieve your condition:

☐ sitting	☐ leaning for support	☐ ice	☐ rest
☐ standing	☐ not moving	☐ topical gel	☐ stretching/ exercise

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

Circle the activities that aggravate your condition(s):

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

Would you like improvement with any of the following?:

☐ **Digestion:** Reflux, Gas, Constipation
☐ **Skin**: Rash, dryness, acne, eczema
☐ **Weight**: loss, distribution, management
☐ **Sleep:** Falling asleep or staying asleep
☐ Sense of Well Being
☐ **Hormones:** sex drive, mood swings, PMS, fertility
☐ Energy Levels, Brain Fog, Fatigue
☐ **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						
Infertillity						
Insomina						
Kidney trouble						
Neck pain						
Nervousness						
Obesity						
Pinched nerve						
Scollosis						
Sinus trouble						
Other						

Additional Comments: _____

_____

_____