Yajima Chiropractic & Wellness

Registration Form

Today's Date _____

Patient Information

Last Name	First	Middle Initial	▢ Mr. ▢ Mrs.▢ Miss ▢ Ms.	▢ Single ▢ Married ▢ Divorced ▢ Widowed

Height	Weight	Birth Date	Age	Sex ▢ M ▢ F

Street Address	City	State	Zip	Home Phone #
E-Mail				Cell Phone #

Occupation	Employer
Spouse's Name	Spouse's Phone #
Emergency Contact Name	Emergency Contact #

Whom may we thank for referring you?

_____

Patient Condition

Reason for Visit_____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes ▢ No ▢

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: ▢ Sharp ▢ Dull ▢ Throbbing ▢ Numbness ▢ Aching ▢ Shooting
▢ Burning ▢ Tingling ▢ Cramps ▢ Stiffness ▢ Swelling ▢ Other

How often do you have this pain? _____

Does it interfere with your: ▢ Work ▢ Sleep ▢ Daily Routine ▢ Recreation

Activities or movements that are painful to perform: ▢ Sitting ▢ Standing ▢ Walking ▢ Bending ▢ Lying Down

Health History

What treatment have you already received for you condition?

▢ Medications ▢ Surgery ▢ Physical Therapy ▢ Chiropractic Services ▢ None ▢ Other_____

Name and address of other doctor(s) who have treated you for you condition

Date of last:

Physical Exam_____ X-Rays_____ (Which body part?)_____ Blood Test_____ Spinal Exam_____

Urine Test_____ MRI, CT/Bone Scan_____

Are you right/left handed? ▢ Right ▢ Left

Are you pregnant? ▢ Yes ▢ No Due Date:_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Alcoholism	▢ Yes ▢ No	Gout	▢ Yes ▢ No	Prostate Problem	▢ Yes ▢ No
Anemia	▢ Yes ▢ No	Heart Disease	▢ Yes ▢ No	Psycho Emotional	▢ Yes ▢ No
Anorexia	▢ Yes ▢ No	Hepatitis	▢ Yes ▢ No	Problem	▢ Yes ▢ No
Appendicitis	▢ Yes ▢ No	Hernia	▢ Yes ▢ No	Rheumatoid Arthritis	▢ Yes ▢ No
Arthritis	▢ Yes ▢ No	Herniated Disk	▢ Yes ▢ No	Stroke	▢ Yes ▢ No
Asthma	▢ Yes ▢ No	High Blood Pressure	▢ Yes ▢ No	Suicide Attempt	▢ Yes ▢ No
Brain Fog	▢ Yes ▢ No	High Cholesterol	▢ Yes ▢ No	Thyroid Problems	▢ Yes ▢ No
Breast Implants/	▢ Yes ▢ No	Kidney Disease	▢ Yes ▢ No	Tumors, Growths	▢ Yes ▢ No
Reduction		Liver Disease	▢ Yes ▢ No	Other (Please describe)	▢ Yes ▢ No
Bronchitis	▢ Yes ▢ No	Migraine	▢ Yes ▢ No	_____	_____
Bulimia	▢ Yes ▢ No	Headache			
Cancer	▢ Yes ▢ No	Miscarriage	▢ Yes ▢ No	_____	_____
Cataracts	▢ Yes ▢ No	Osteoporosis	▢ Yes ▢ No		
Chicken Pox	▢ Yes ▢ No	Pacemaker	▢ Yes ▢ No		
Diabetes	▢ Yes ▢ No	Pinched Nerve	▢ Yes ▢ No		
Emphysema	▢ Yes ▢ No	Pneumonia	▢ Yes ▢ No		

Exercise	**Work Activity**		**Habits**
▢ None	▢ Sitting	▢ Smoking	Packs/Day_____
▢ Moderate	▢ Standing	▢ Alcohol	Drinks/Week_____
▢ Daily	▢ Light Labor	▢ Coffee/Caffeine Drinks	Cups/Day_____
▢ Heavy	▢ Heavy Labor	▢ High Stress	Reason_____

Past Injuries/Surgeries	**Description**	**Date**
Neck/Back Injury		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	**Allergies**	**Vitamins/ Herbs/ Minerals**
•	•	•
•	•	•
•	•	•
•	•	•

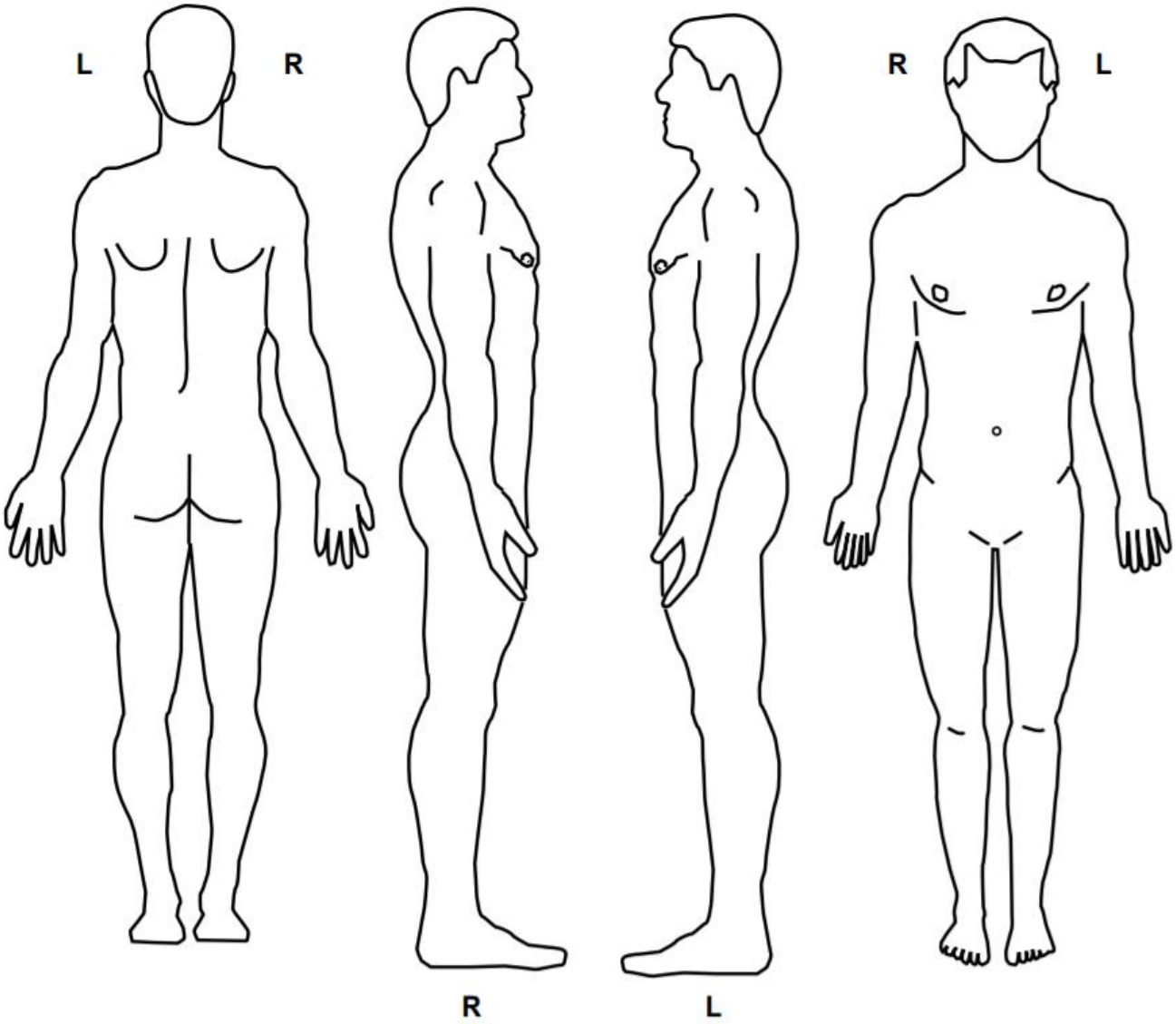
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Hajime Yajima. I understand that I am financially responsible for any and all balance(s). I also authorize Yajima Chiropractic & Wellness Corporation to release any information pertinent to my case to my insurance company, adjuster or attorney involved in my case.

X_____

PATIENT/GUARDIAN SIGNATURE DATE

PAIN DRAWING

PATIENT NAME: _____ DATE: _____



Mark as follows:

A – Ache B – Burning N – Numbness

P – Pins & Needles S – Stabbing

O – Other (Describe): _____

_____