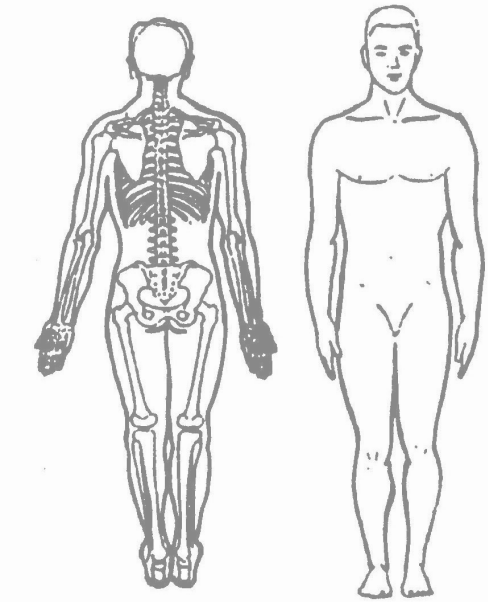
Pacific Life Chiropractic
Dr. Barbara Onedera-Gregory
Dr. Robert W. Gregory
Family Wellness Care

PACIFIC LIFE CHIROPRACTIC PATIENT REGISTRATION FORM

Name: _____ DOB: ___/___/___ Age: _____Date:_____
Mailing Address:_____
Home Phone:_____ Work Phone: _____ Cell:_____ Male ___ Female __
SS#_____ E-mail Address _____
Employer's Name/Address _____ Occupation _____
Marital Status _____ Spouse's Name _____ Occupation _____
No. of Children _____ Name's/Ages _____
_____
Reason for consulting our office? _____
_____
Who may we "Thank" for referring you to our office? _____

PLEASE ILLUSTRATE AFFECTED AREAS



COMPLETE THESE DIAGRAMS

Please place an "X" on the drawing to the left on areas causing you pain and a letter describing it.

A=ache B=burning S=Sore ST=stabbing N=numbness P=pins/needles

MAJOR COMPLAINTS
(Please list any conditions you are feeling or being treated for)

_____
_____
_____
_____
_____
_____

Have you ever been in an Auto Accident? Past Year ___ Past 5 Years __Over 5 years ___ Never____
Attorney Name (if applicable) _____

Is your condition due to an accident? □ Yes □ No Date _____
Type of Accident? □ Auto □ Work □ Home Other _____

To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Worker Comp. □ Other

On a scale of POOR, GOOD OR EXCELLENT describe your:
Diet _____**Exercise**_____ **Sleep**_____ **General Health**_____
# of hours of Sleep_____

On a scale from 1-10 describe your stress level:(1=none/10=Extreme)
Personal _____ **Occupational** _____

Addressing The Issues That Brought You to Pacific Life Chiropractic

Please briefly describe the chief area of complaint, including the affect it has had on your life._____

_____

_____

When did it start?_____

If you are experiencing pain is it...

□ Sharp □ Dull □ Comes & Goes □ Travels □ Constant

Since the problem started, it is... □ About the Same □ Getting Better □ Getting Worse

What makes it worse: _____

What makes it better?_____

Yes, it interferes with... □ Work □ Sleep □ Walking □ Sitting □ Hobbies □ Leisure

Have you ever seen a Chiropractor in the past?_____

If yes, when was your last adjustment?_____

Doctors seen for this problem (please list names and specialties):

□ Chiropractor(s): _____

□ Medical Doctor(s):_____

□ Other: _____

List any Health Conditions you have:_____

List any medications you are taking:_____

List Surgical Operations and dates:_____

_____

Any History of Stroke, Heart attack, breast augmentation, plastic surgery, etc.

_____

Have you ever:	YES	NO	DATE and DESCRIBE BRIEFLY
Been knocked unconscious?	☐	☐	_____
Used a cane, crutch, or other?	☐	☐	_____
Been treated for spine or nerve disorder	☐	☐	_____
Fractured a bone?	☐	☐	_____
Been Hospitalized other than Surgery?	☐	☐	_____
Had any other injuries or trauma?	☐	☐	_____

For Women:

Are you pregnant?	**Yes**	**No**
Are you breastfeeding?	**Yes**	**No**

Name _____Date_____

PACIFIC LIFE CHIROPRACTIC HEALTH PROFILE (continued)

AGE 5 - PRESENT

	YES	NO	COMMENTS
1.PHYSICAL			
Do/did you have any injuries/accidents?	☐	☐	_____
Have you fallen/jumped from a height over 3 feet (ie. Crib, bunk bed, tree)	☐	☐	_____
Do/did you have any illnesses?	☐	☐	_____
Do/did you play sports?	☐	☐	_____
Have you had any major surgeries or medical procedures?	☐	☐	_____
Have you had any exercise problems or injuries?	☐	☐	_____
Do you exercise? Regularly, Rarely or Never?	☐	☐	_____
Do you belong to a health or fitness club?	☐	☐	_____
2. CHEMICAL			
Do/did you smoke? Or any tobacco products?	☐	☐	_____
Are/were you exposed to second-hand smoke?	☐	☐	_____
Do/did you drink alcohol? How much per week? (circle)	☐	☐	regularly irregularly rarely never
Do/did you use recreational drugs? (circle)	☐	☐	regularly irregularly rarely never
Do/did you use over-the-counter drugs?	☐	☐	regularly irregularly rarely never
Do you consume vitamin or herbal supplements?	☐	☐	_____
Do you drink bottled water?	☐	☐	_____
3. EMOTIONAL			
Do you have occupational (job) stress?	☐	☐	_____
Do you have home or family stress?	☐	☐	_____
Do/did you experience any other kind of emotional stress?	☐	☐	_____
Do you have a preferred sleeping posture? (circle)	☐	☐	L side R side stomach back restless
Have you ever or do you now have sleeping difficulty?	☐	☐	_____

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Spouse _____
Children _____
Mother _____
Father _____
Sisters(s) _____
Brother(s) _____
Other Relative(s) _____
Friend(s) _____

AUTHORIZATION

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation and treatment. I also understand it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

The purpose for spinal adjustments is the reduction of vertebral subluxation and joint malposition. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

_____
Signature

Name _____ Date _____