**Patient Registration & Health History**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex:  Male  Female

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_ Phone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Primary Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Single  Married  Divorced  Widowed Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ In Case of Emergency Call\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had Chiropractic care before? Yes  No  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Name of party responsible for payment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have health insurance? Yes  No  Name of company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* If reason for visit is an auto accident, please provide: Auto Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you want us to bill to your Insurance, please sign this Assignment and Release**  
I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_ and assign directly to Dr.Jonathan Zuchowski, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions . The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies ) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s or guardian’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Why Chiropractic**? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your doctor will weigh your needs and desires when recommending your treatment program. Please check the box for the type of care that best meets your needs.

🡨

RELIEF CARE:

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it.

CORRECTIVE CARE:

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time but is more lasting.

🡪

**Health History**

Do you have any allergies? Yes No if yes Specify type(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Check All Current Problems You Have:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Dizziness  Headaches  Vertigo  Ear Infections  Nausea  TMJ  Neck Pain  Migraines  Throat Issues  Chronic Sinus  Loss of Consciousness | Asthma  Numbness in Arms  Numbness in Hands  Mid Back Pain  Shoulder pain  Arm Pain  Chest Pain  Nasua/Vomiting  Heart Disorders  High/low Blood Pressure  Liver Disease | Stomach Disorders  Bladder Problems  Thyroid Problems  Kidney Problems  Low Back Pain  Numbness in Legs  Numbness in Feet  Sciatica  Leg Pain  Knee Pain  Hip Pain | Anxiety  ADHD/ADD  Depression  Nervousness  Epilepsy  Infertility  Menstrual Disorder  Chronic Fatigue  Gastric Reflux  Lupus  Fibromyalgia | Diabetes  Disc Problem  Broken/Fractured bones  Gout  Constipation/ Diarrhea  Other: 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Family Health History**

Family History: Please write who the relation is and how old they were when had the disease, including yourself.

Alzheimer’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Headache \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Backache \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Depression\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dementia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes (1/ 2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Osteoporosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spinal Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Anxiety \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abdominal Aortic Aneurysm (AAA):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician**:

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone#: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescription Medications**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date started \_\_\_/\_\_\_/\_\_\_\_\_ date stopped \_\_\_/\_\_\_/\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date started \_\_\_/\_\_\_/\_\_\_\_\_ date stopped \_\_\_/\_\_\_/\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date started \_\_\_/\_\_\_/\_\_\_\_\_ date stopped \_\_\_/\_\_\_/\_\_\_\_ Please list any additional medications on the back of this form Vitamins / Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ prescribed by Dr? Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ prescribed by Dr? Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ prescribed by Dr? Y N

**History of Health Concerns**

*If you have additional symptoms (3+) and require another symptom sheet, please ask for an “Additional Symptom” form*

Please start at the top of your body and work your way down

Please mark on the diagram with the following letters to describe your symptoms:

**R**=Radiating **B**=Burning **D**=Dull **A**=Aching **S**=Sharp/Stabbing **T**=Tingling **N**=Numbness

![A diagram of a human body

Description automatically generated with medium confidence]()

Symptom 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• On a scale of 1 – 10, 10 being the worst pain you’ve ever felt,

what is the severity of your symptom?

1 2 3 4 5 6 7 8 9 10

• What percent of the time do you feel the symptom?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

• When did this episode begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Did it begin:  Suddenly  Gradually

• Describe how it began \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Have you had the symptom in the past before?  Yes  No

• If yes, when was the first time you’ve ever felt the symptom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• What makes the symptom worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • What makes the symptom better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • Does the pain radiate?  Yes  No

• If yes, describe in detail where it radiates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Does the pain feel worse at a particular time of day?  Morning  Afternoon  Early evening  Late at night  Unchanged by time of day

Symptom 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mark on the diagram with the following letters to describe your symptoms:

**R**=Radiating **B**=Burning **D**=Dull **A**=Aching **S**=Sharp/Stabbing **T**=Tingling **N**=Numbness

![A diagram of a human body

Description automatically generated with medium confidence]()

• On a scale of 1 – 10, 10 being the worst pain you’ve ever felt,

what is the severity of your symptom?

1 2 3 4 5 6 7 8 9 10

• What percent of the time do you feel the symptom?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

• When did this episode begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Did it begin:  Suddenly  Gradually

• Describe how it began \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Have you had the symptom in the past before?  Yes  No

• If yes, when was the first time you’ve ever felt the symptom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• What makes the symptom worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • What makes the symptom better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • Does the pain radiate?  Yes  No

• If yes, describe in detail where it radiates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Does the pain feel worse at a particular time of day?  Morning  Afternoon  Early evening  Late at night  Unchanged by time of day

**Patients Desire for Care Outcomes(s)**

Are you interested in anything in particular as a result of your care, if so, please list below



\*Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

**Smoking**: Cigars Pipe Cigarettes E-Cigarettes **🡪** **How Often?** Daily Weekends Occasionally Never **Alcoholic Beverages**: Consumption occurs: **🡪** Daily Weekends Occasionally Never **Recreational Drug Use**: **🡪** Daily Weekends Occasionally Never **Caffeine intake**:  Coffee Tea Energy Drink **🡪** Daily Weekends Occasionally Never **Do you exercise?** Yes No  **🡪**  1x 2x 3x 4x 5x per week Other\_\_\_\_\_\_\_\_\_ **If Yes Than What Activities?** Running/ Walking Weight Training Cycling Yoga/Pilates Other\_\_\_\_\_\_\_\_\_ **Hobbies** How does your present problem affect the following: Recreational Activities Exercise Regime *Please Explain*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Activities of Life**

*Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Activities** | **No Effect** | **Painful (can do)** | **Painful (limits)** | **Unable to Perform** |
| Carrying Groceries |  |  |  |  |
| Lifting Groceries |  |  |  |  |
| Sit to Stand |  |  |  |  |
| Climbing Stairs |  |  |  |  |
| Pet Care |  |  |  |  |
| Driving |  |  |  |  |
| Extended Computer Use |  |  |  |  |
| Household Chores |  |  |  |  |
| Lifting Children |  |  |  |  |
| Concentration (reading) |  |  |  |  |
| Bathing |  |  |  |  |
| Dressing |  |  |  |  |
| Shaving |  |  |  |  |
| Sexual Activities |  |  |  |  |
| Sleep |  |  |  |  |
| Static Siting |  |  |  |  |
| Static Standing |  |  |  |  |
| Yard Work |  |  |  |  |
| Walking |  |  |  |  |
| Washing/Bathing |  |  |  |  |
| Sweeping/ Vacuuming |  |  |  |  |
| Dishes |  |  |  |  |
| Laundry |  |  |  |  |
| Garbage |  |  |  |  |
| Dressing |  |  |  |  |
| Other: |  |  |  |  |