Chiropractic 503
Ryan McDaid, D.C.
503-371-2044
1645 12th St SE
Salem, OR 97302
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Patient Registration Form

Date:_____

Patient Name:_____ Date of Birth:_____

Preferred Name:_____ Marital Status: S M D W DP Sex: M / F

Address:_____
Street City State Zip Code

Home Number:_____ Cell Number:_____

Email Address:_____

What is your preferred method of appointment reminder? Text ☐ Voicemail ☐ Email ☐

Occupation:_____ Employer:_____ Work Number:_____

Emergency Contact:_____ Phone Number:_____

Insurance Information:

Your Private Health Insurance Company:_____ ID#:_____

ARE YOU THE PRIMARY ON THIS INSURANCE? ☐ Yes ☐ No

If you are not the primary please provide the following for the primary subscriber:

Name: _____

Date of Birth:_____

Phone number:_____

Address:_____

Primary Care Physician:_____ Phone Number:_____

May we contact your physician regarding your care here? ☐ Yes ☐ No

How were you referred to our office?

☐ Friend / Family Member:_____ ☐ Doctor:_____

☐ Insurance Company:_____ ☐ Internet:_____

☐ Other:_____

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Patient Name: _____ DOB: _____ Date: _____

Patient Health Questionnaire

What is your **main area** of complaint?

_____

Please list ***ALL*** other areas of complaint:

_____

When did your symptoms with this episode start? (**Date Required**) MM/ DD/ YY

Please describe the event/activity that led to your symptoms:

_____

Have your symptoms **improved**, **worsened**, or **stayed the same** since they began? **(circle one)**

How often do you experience your symptoms?

◯ **Constantly (76%-100% of the time)** ② **Frequently (51%-75% of the time)**

◯ **Occasionally (26%-50% of the time)** ④ **Intermittently (0%-25% of the time)**

Describe your pain: **(circle all that apply)** Achy Sharp Stabbing Shooting Burning

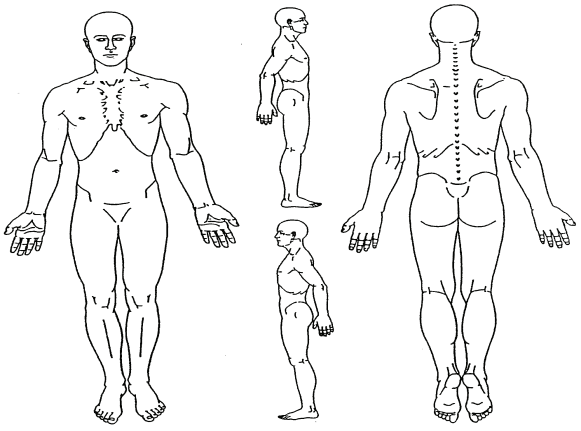
Other: _____

Pain intensity: **(circle)** Mild Moderate Severe Other:_____

Average Pain Intensity: (QNRS)

current:	**no pain**	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩ **worst pain imaginable**
average/typical:	**no pain**	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩ **worst pain imaginable**
best:	**no pain**	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩ **worst pain imaginable**
worst:	**no pain**	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩ **worst pain imaginable**

Indicate where you feel your symptoms with X's



Do you have any headaches associated with your symptoms? (**circle one**) YES NO

Do you have any of the following symptoms into either your arm(s) and/or leg(s)? (**circle all that apply**) Numbness Tingling Weakness Pain Other:_____ None

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Patient Health Questionnaire continued

How much have your symptoms interfered with your usual daily activities?

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

What makes your symptoms **WORSE**? _____

What makes your symptoms **BETTER**? _____

In general, how would you say your overall health is right now?

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Have you had any recent symptoms of (**circle all that apply**):

Fever Fatigue Nausea Vomiting Diarrhea Loss of Appetite Malaise None

Who have you seen for your symptoms? **(1) No One (2) Other Chiropractor (3) Medical Doctor (4) Physical Therapist (5) Acupuncturist (6) Other: _____**

Have you received any treatments or medication? (**circle one**) YES NO

If yes, what treatment(s) and/or medication(s)?

_____

Have you had any tests/imaging for your symptoms? (**circle one**) YES NO

If yes, please circle all that apply and list the date the examination was performed:

X-Ray date:_____ MRI date:_____ CT scan date:_____ Other test date:_____

Patient Signature:_____ Date:_____

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Patient Name: _____ DOB: _____ Date: _____

Overall Health Status

Please **check all** of the following that apply to you:

- ☐ Abnormal Weight: Gain / Loss
- ☐ Allergies: _____
- ☐ Corticosteroids Used (Cortisone, Prednisone, etc.)
- ☐ Currently Pregnant: weeks____
- ☐ Diabetes
- ☐ Dizziness / Fainting
- ☐ Epilepsy / Seizures
- ☐ Heart Attack (date):_____
- ☐ High Blood Pressure
- ☐ Menstrual Problems
- ☐ Morning Pain / Stiffness
- ☐ Numbness in Groin / Buttocks (date):_____
- ☐ Osteoporosis
- ☐ Pain at Night that awakens you from sleep
- ☐ Pain Unrelieved by Position or Rest
- ☐ Prostate Problems
- ☐ Recent Fever
- ☐ Stroke
- ☐ Taking Birth Control
- ☐ Tobacco Use Type:_____
- ☐ Urinary Problems
- ☐ Visual Disturbances

☐ Cancer / Tumor (Explain):_____

_____

☐ Surgeries: _____

_____

☐ Medications: _____

_____

☐ Serious Illnesses (Tuberculosis, Hepatitis, HIV, etc.): _____

☐ Other Health Problems (explain): _____

_____

Family History:

- ☐ Heart Problems / Disease
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Stroke

I certify to the best of my knowledge that the above information is complete and accurate. I agree to notify this office and my treating provider immediately whenever I have any changes in my health condition or health plan/insurance coverage in the future.

Patient Signature:_____ **Date:**_____

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