

Callahan Chiropractic Center
1100 North Lincoln Ave
York, NE 68467
(402)362-3251

PATIENT REGISTRATION

NAME _____ TODAY'S DATE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE _____ CELL PHONE _____ SOC. SEC.# _____
DATE OF BIRTH _____ AGE _____ SEX _____ MARITAL STATUS _____
OCCUPATION _____ EMPLOYER _____
WORK PHONE _____ SPOUSE NAME _____
REFERRED BY : YELLOWPAGES _____ NEWSPAPER _____ BILLBOARD _____ WEBSITE _____
PERSONAL _____ NAME OF REFERRING PERSON _____

MAJOR PAIN/PROBLEM TODAY _____
HOW DID IT HAPPEN _____
TODAY'S PAIN/PROBLEM STARTED WHEN _____
PAINS ARE: SHARP _____ DULL _____ CONSTANT _____ INTERMITTENT _____
ANY HOME REMEDIES _____
WHAT MEDICATIONS ARE YOU TAKING _____
ARE YOU PREGNANT _____ WHEN WERE YOU LAST X-RAYED _____
PREVIOUS SERIOUS ILLNESS _____
FAMILY HISTORY OF: HEART DISEASE _____ CANCER _____ DIABETES _____
ARTHRITIS _____ BACK PROBLEMS _____ DISC PROBLEMS _____

CHECK SYMPTOMS YOU'VE NOTICED: USE **N** IF PROBLEM NOW, USE **P** IF PROBLEM IN THE PAST, LEAVE **BLANK** IF OK

- | | | |
|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in shoulder | <input type="checkbox"/> Low back pains |
| <input type="checkbox"/> Head feels heavy | <input type="checkbox"/> Muscle spasm in shoulder | <input type="checkbox"/> Low back muscle spasm |
| <input type="checkbox"/> Light headed | <input type="checkbox"/> Pain in neck | <input type="checkbox"/> Pain into buttock |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Pain into thigh |
| <input type="checkbox"/> Dizzy | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Pain down leg |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Pain in arms and hands | <input type="checkbox"/> Pain in ankle |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pins and needles in arms and hands | <input type="checkbox"/> Pain in foot |
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Loss of grip strength | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Carpal tunnel | <input type="checkbox"/> Depression |

PLEASE MARK AREA & TYPE OF PAIN ON THE DIAGRAMS USING THE CODES LISTED BELOW.
ON A SCALE OF 1- 10:

I would rate the intensity of my symptoms as:
0 1 2 3 4 5 6 7 8 9 10
Very mild Mild Moderate Severe

I feel the symptoms:
0 1 2 3 4 5 6 7 8 9 10
Never Seldom On & Off Constant

Signature _____ Date _____