
**PATIENT REGISTRATION** *(Please print clearly)*

Name_____Date_____

Address_____City_____State_____Zip_____

Phone (mobile) _____(work) _____(home) _____

Email Address_____Marital Status: S M D W

Age_____Birth Date_____Time of Birth _____

Employer_____Type of Work_____

Address_____City_____State_____Zip_____

How were you referred to my practice?

_____

**SPOUSE and CHILDREN INFORMATION**

Name of spouse_____

Number of children_____ Ages_____

Employer_____Type of Work_____

Address_____City_____State_____Zip_____

**EMERGENCY INFORMATION**
*(In case of an emergency, the name, address, and phone number of a close relative)*

Name_____Date_____

Address_____City_____State_____Zip_____

Phone (mobile) _____(work) _____(home) _____

Relationship_____

**Have you ever received chiropractic care?** YES NO

If YES, please provide doctor's name_____

**Have you ever received acupuncture care?** YES NO

If YES, please provide practitioner's name_____

**MAJOR COMPLAINT(S)**
*(What caused you to seek treatment here?)*

| | Symptom | Duration | Impact on living/working |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |

**How did it start?** ☐ Gradually ☐ Suddenly (accident) Date_____

**Have you lost any time from work or other activities as a result of this condition?**

☐ NO ☐ YES From _____To _____

**Frequency of symptoms**

☐ Intermittent ☐ Occasional (25%)
☐ Infrequent (50%) ☐ Frequent (75%)
☐ Constant (100%) ☐ With movement or position

**Does the pain radiate to other parts of your body?** ☐ NO ☐ YES, where?

_____

**What makes your pain or condition worse?**

☐ Bending ☐ Lifting ☐ Standing ☐ Driving
☐ Coughing ☐ Pulling ☐ Sitting ☐ Walking
☐ Sneezing ☐ Pushing ☐ Other_____

**What makes your pain or condition better?**

☐ Cold Pack ☐ Hot Pack ☐ Rest ☐ Lying Down
☐ Exercise ☐ Sitting ☐ Standing ☐ Other_____

**Have you ever had this condition before?** ☐ NO ☐ YES, when?

_____

**Have you ever had any treatment for this condition?** ☐ NO ☐ YES, when?

_____

**Have you ever been involved in a car or motorcycle accident or traumatic fall?**
☐ NO ☐ YES When? Please describe.

_____

**Have you ever had any surgery?** ☐ NO ☐ YES, when? Please explain.

_____

**Do you exercise?** ☐ NO ☐ YES, what type and how often?

_____

**Do you take vitamins/supplements?** ☐ NO ☐ YES, which one(s) and how often?

_____ _____

_____ _____

_____ _____

_____ _____

**Are you taking any medication or hormones?** ☐ NO ☐ YES (please list below)

| Name | Purpose |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Please describe your daily duties (*home or work*) from a physical perspective** (e.g., I lift cases of supplies five hours per day and drive a truck three hours per day, *or* I sit at a computer and answer phones eight hours per day)

_____

_____

**Is your job stressful?** ☐ NO ☐ YES, please explain.

_____

_____

**What percentage of time do you sit each day?** _____% at home _____% at work

**Are your parents living?** ☐ YES ☐ NO, please list cause of death.

_____

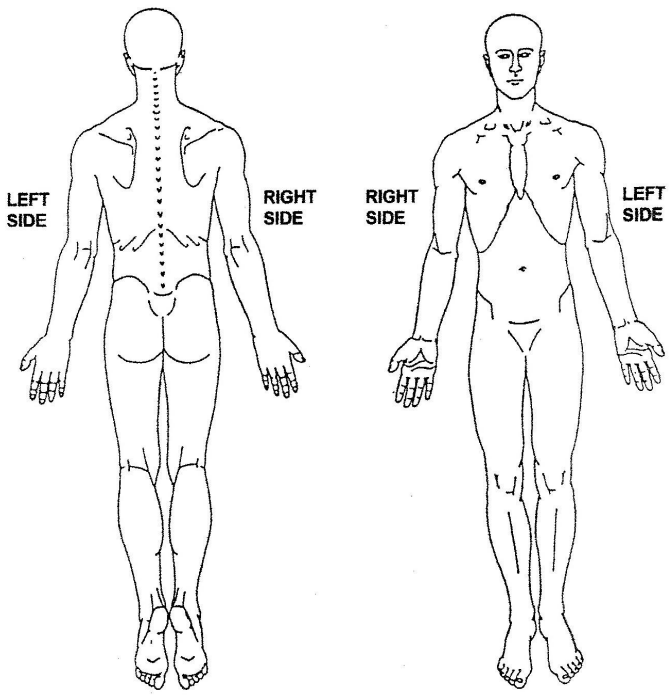
**Please indicate if any member of your family has had any of the following illnesses.**
**Use these codes: M**=Mother, **F**=Father, **B**=Brother, **S**=Sister

| | | |
|---|---|---|
| ☐ Arthritis | ☐ Headaches | ☐ Neck pain |
| ☐ Back pain | ☐ Heart disorder | ☐ Spinal problems |
| ☐ Cancer | ☐ High blood pressure | ☐ Stroke |
| ☐ Diabetes | ☐ Intestinal disorder | ☐ Thyroid dysfunction |

**Indicate where you are experiencing your symptoms listed below by circling the area on the body diagram:**

**Use these codes:** Pain**(P) /** Stiffness **(S)** / Swelling **(SW)** / Aching **(A)** / Numbness **(N)** / Tingling **(T)** / Burning **(B)**

____ Head ____ Face
____ Neck ____ Trapezius
____ Upper back ____ Shoulders
____ Arms ____ Elbows
____ Wrists ____ Hands
____ Mid back ____ Low back
____ Sacral iliac ____ Hips
____ Buttocks ____ Legs
____ Knees ____ Ankles
____ Feet
____ Other (please list)
_____
_____
_____



Please rate symptoms on a scale from 0-10, where 10 is the worst.

NEW PATIENTS: Indicate any symptoms you have experienced in the past 6 months.

CURRENT PATIENTS: Indicate any symptoms you're currently experiencing.

WOMEN Only:

Last menstrual period: _____
Length of menses: _____
____ Regular cycle
____ Irregular cycle
____ Early (fewer than 28 days)
____ Late (more than 28 days)
____ Skip cycle
____ Flow: Light / Moderate / Heavy
____ Cramps: Mild / Moderate / Severe
____ Clotting / Spotting
____ Headache on side of head
____ Sex drive: Flat / Low / Normal
____ Low abdominal puffiness
____ Fluid retention: Face / Hands / Feet
____ Mood swings/irritability/depression
____ Tired during cycle
____ Menopausal: natural / surgical
____ Hot flashes

WOMEN Only:

____ Ovarian pain
____ Breasts tender around cycle
____ Acne around cycle: pre/mid/post
____ Birth control pill / patch
____ Facial hair growth
____ Dark nipple hair
____ Hair growing up towards belly button
____ Skin crawling
____ Breast discharge
____ Breasts shrinking
____ Breast feeding
____ Breast surgery
____ Vaginal burning
____ Vaginal itchiness
____ Dry Vagina
____ Discharge: clear/white/yellow/green/brown
____ Pain with intercourse

MEN Only:

____ Sex drive: Flat / Low / Normal
____ Decreased morning erections
____ Decreased fullness erections
____ Inability to concentrate
____ Episodes of depression
____ Decreased physical stamina
____ Sweating attacks
____ More emotional than in past
____ Weight gain (unexplained)

ALL PATIENTS:

___ Energy Low / Normal / High
___ Insomnia
___ Slow to start in morning
___ Energy crash: _____ am/pm
___ Dizzy when standing up quickly
___ Light bothers eyes
___ Weak nails
___ Perspire easily or excessively
___ Splitting Headaches
___ Tired/Sluggish
___ Chills, cold hands/feet, cold bod
___ Require excessive sleep
___ Increase in weight (unexplained)
___ Hair loss and/or thinning
___ Thinning of outer third of eyebrow
___ Scalp dryness
___ Mental sluggishness
___ Heart palpitations- skip/flutter
___ Inward trembling

___ Stress
___ Sadness
___ Grief
___ Depression
___ Moodiness
___ Frustration
___ Irritability
___ Anger
___ Worriedness
___ Nervousness
___ Anxiety
___ Panic
___ Crying
___ Fear
___ Shame
___ Guilt

___ Forget names
___ Forget numbers
___ Forget words
___ Forget actions

___ Eyes: burning/red/dry
___ Excessive tears
___ Eye film/crust in morning
___ Eye floaters
___ Eye stye(s)
___ Itchy eyes
___ Eye aches
___ Blurry vision
___ Tired eyes
___ Eye spots
___ Eyes puffy
___ Dark circles under eyes
___ Ear noise: ring/hiss/pound
___ Ears plugged
___ Ear popping
___ Earache / infection
___ Ears itch internally
___ Ear drainage
___ Hearing loss
___ Excessive ear wax
___ Dizziness/vertigo

___ Urinate:__ times/day __times/night
___ Urination urgency
___ Burning/painful urination
___ Cloudy urine
___ Odor in urine
___ Spasm when urinating
___ Urinary Tract Infection (UTI)
___ Kidney pain or infections
___ Frequent urination
___ Urination leakage
___ Pain inside of legs or heels
___ Leg twitching at night
___ Headache side of head

___ Heartburn
___ Indigestion
___ Stomach aches
___ Stomach cramps
___ Nausea / Queasy
___ Bloated after eating

___ Increased pulse at rest
___ Night sweats

___ Twitching around eyes
___ Restlessness
___ Don't remember dreams
___ Nails: spots / weakness
___ Air hunger / frequent sighs
___ Cramps: legs/feet/arms/hands
___ Aches: legs/feet/arms/hands
___ Restless: legs/feet/arms/hands
___ Frequent thirst
___ Shallow rapid breathing
___ Poor muscle endurance
___ Swelling in ankles and wrists

___ Chest congestion
___ Pain on breastbone
___ Breath short on exertion
___ Wheezing
___ Asthma
___ Emphysema
___ Bronchitis
___ Frontal headache
___ Sinus: dry
___ Sinus: post-nasal drip
___ Sinus: stuffy
___ Sneeze frequently
___ Smell / Taste loss

___ Mucous:
clear/white/yellow/green/brown
___ Fever
___ Cough: dry / productive
___ Frequent colds/flu
___ Environmental allergies
___ Nightmares

___ Difficulty focusing / concentrating
___ Sluggish memory

___ Crave sweets
___ Irritable if skipping meals
___ Light-headed if skipping meals
___ Eating relieves fatigue
___ Bouts of blurred vision
___ Fatigued after meals
___ Increased thirst
___ Difficulty losing weight
___ Constant fatigue
___ Dehydrated
___ Slow to heal
___ Low stamina
___ Inability to achieve lean body

Sleep quality: poor/fair/good/great
__ Hours in bed; __ hours asleep
___ Interrupted _____ per night
___ Awaken suddenly (jolt)

Appetite: low / normal / high
___ Eat animal protein: _____ /day
___ Eat chocolate: _____ /week
___ Eat spicy foods: _____ /week
___ Eat ice cream: _____ /week
___ Coffee: _____ cups/week
___ Tea: _____cups/week
___ Juice: _____ per week
___ Soda: _____ per week

___ Beer: _____ per week
___ Wine: _____ per week
___ Liquor: _____ per week
___ Special diet?: _____

___ Mouth/Throat blisters
___ Canker sores
___ Bad breath
___ Bleeding gums
___ Receding gums
___ Dental health problems
___ Dry mouth
___ Swelling of glands
___ Difficulty swallowing
___ Sore throat
___ Hoarseness

___ Skin rash
___ Acne
___ Dry/ Itchy skin
___Nail fungus: mild/mod/severe

___ Chest tension/tightness
___ Chest heaviness
___ Chest/Heart pain
___ Heart palpitations- skip/flutter
___ Heart racing
___ Heart slowing down
___ Sleep apnea
___ Mitral Valve Prolapse
___ Murmur

___ Headaches at base of skull
___ Yellow cast to eyes
___ History of gallbladder attacks

___ Excessively foul-smelling sweat
___ Hormonal imbalances

___ Cardio exercise: ____ /week
___ Weight training: ____/week

___ Gas / flatulence
___ Belching
___ Ulcer
___ Hiatal Hernia
___ Greasy high-fat foods cause distress

___ Swollen/distended/bloody anus
___ Burning anus
___ Itchy/stinging anus
___ Achy anus

___ Bowel movements _____ per day
___ Regular
___ Incomplete
___ Skip days: ___ per (week/month)
___ Sluggish bowels every: _____ days
___ Cramps in abdomen
___ Taking laxatives
___ Using suppositories
___ Enemas
___ Colonics
___ Pain with bowel movements
___ Irritable Bowel Syndrome
___ Chron's Disease
Color of feces: light / dark
Fecal consistency:
___ Normal
___ Soft
___ Hard
___ Pebble-like
___ Dry
___ Ribbon-like
___ Bulky
___ Mucous
___ Diarrhea
___ Constipation

- The above information is accurate and complete to the best of my knowledge. I have disclosed all past and present medical information, with the understanding that it is important for proper and accurate diagnosis.

- I agree to pay in full the charges incurred by myself for services rendered at the time of each visit. If for any reason this request cannot be met, arrangements must be made in advance with Dr. Wonson.

- I understand Dr. Wonson's practice requires a 48-hour advance notice. When I give a 48-hour advance notice, my appointment can be offered to another patient. In this case, I will not be charged any fee. However, for appointments I cancel or reschedule with less than 48-hour notice, no matter the reason, I will be charged for the full visit fee. I agree to keep a credit card on file which will be charged for my no show or late cancellation fees.

- I agree to receive mandatory practice notices and optional patient education (twice monthly) electronic communications at the email address given above. If I don't want to receive optional patient education, I will be able to opt-out.

Patient Signature:_____Date:_____