21 West Robert Toombs Avenue

Washington, GA 30673

(706) 678-3292

Patient Registration PDF version

Please complete all applicable sections of form. Contact us if you have any questions.

General Information

* Indicates Required

Full name *

First Name Last Name

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Primary phone number *

Area Code Phone Number

Email

example@example.com

Date of birth *

Month Day Year

Age

Sex *

- ◯ Male
- ◯ Female

Marital status

- ◯ Single
- ◯ Divorced
- ◯ Married
- ◯ Widowed

Number of children

Employer

Years employed

Occupation

Employer's Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Spouse/partner's occupation

Spouse/partner's employer

Person responsible for this account

Nearest relative not living with you

Emergency contact

Emergency contact phone number

Area Code Phone Number

What is your chief complaint? *

Other complaints

Cause of condition

Have you had similar conditions in the past?

- ◯ Yes
- ◯ No

If yes, please explain

What activities aggravate your condition?

Who referred you to our office today?

First Name Last Name

Other doctors you have seen for this condition

Other doctors you have seen for this condition

- ☐ MD
- ☐ DC
- ☐ DO
- ☐ DDS

Doctor's name

First Name Last Name

Dates treated

Doctor's name

First Name Last Name

Dates treated

Diagnosis

X-rays/dates

MRI (date/region)

Physical therapy dates

Treatment results

Accident information if applicable

Is your condition due to an accident?

- ◯ Yes
- ◯ No

Did accident occur at work?

- ◯ Yes
- ◯ No

Where you involved in an automobile accident?

- ◯ Yes
- ◯ No

If yes, do you have an attorney?

- ◯ Yes
- ◯ No

Date of Accident

Month Day Year

Time of accident

Was accident reported to employer?

- ◯ Yes
- ◯ No

Do you have medical payments coverage on your auto policy?

- ◯ Yes
- ◯ No

Symptoms

General

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Gastrointestinal

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Eye, ear, nose, throat

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - flashes
- ☐ Vision - halos

Muscular, joint, bone (pain, weakness, numbness) in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulder

Genito-urinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Cardiovascular

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Changes in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

WOMEN only

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

Date of last pap smear

Have you had a mammogram?

- ◯ Yes
- ◯ No

Are you pregnant?

- ◯ Yes
- ◯ No

Conditions

Check any conditions you currently have or have had in the past year

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

Medications and allergies

List of medications you are currently taking

Allergies

Pharmacy Name

Pharmacy phone number

Area Code Phone Number

Family history

Health information about your immediate family

	Age	State of health	Age at death	Cause of death
Father				
Mother				
Brother				
Brother				
Brother				
Sister				
Sister				
Sister				

Have any of your blood relatives had any of the following?

	Relationship to you
Arthritis, gout	
Asthma, hay feaver	
Cancer	
Chemical dependency	
Diabetes	
Heart disease, stroke	
High blood pressure	
Kidney disease	
Tuberculosis	
Other	

Hospitalizations

List any hospitalizations

Year	Hospital	Reason for hospitalization and outcome

Pregnancies

Year of birth	Sex of birth	Complications if any

Have you had a blood transfusion?

- ◯ Yes
- ◯ No

If yes, please give approximate dates

Health habits

	Caffeine	Tobacco	Street Drugs	Other
How much do you use				

Occupational - please check if your work exposes you to any of the following

- ☐ Stress
- ☐ Heavy lifting
- ☐ Hazardous substances
- ☐

Terms and conditions

I clearly understand that all services rendered to me are charged directly to me & that I am personally responsible for payment. I also understand that if I suspend or terminate my care & treatment, any fees for professional services rendered to me will be immediately due & payable.

To the best of my knowledge, the information I am submitted is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

*

☐ I have read and agree to the terms and conditions

Signature

Date

Month Day Year

Name of patient, parent, guardian or personal representative

Relationship to patient

TOWNSEND CHIROPRACTIC

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