Dr. Chad K. Frandsen
Wasatch Spine & Wellness

PATIENT REGISTRATION AND HISTORY

Instructions: *Please complete this Patient Registration and History form, as well as any other accompanying documents. Each patient may have a different combination of fill-in forms. Accuracy and completeness are appreciated.*

Patient Background: **Today's Date:** _____

Last Name_____ First Name_____ MI_____ Age_____
Address_____ City _____ State_____ Zip_____
Home Ph (_____) _____ Work Ph (_____) _____Cell Ph (_____) _____
Email Address _____

Date of Birth: ____/____/_____ Referred by: _____
Occupation_____Employer_____
Marital Status: S M D W Spouse's Name_____# of Children _____/Ages_____

Current Conditions: (Select all that apply)

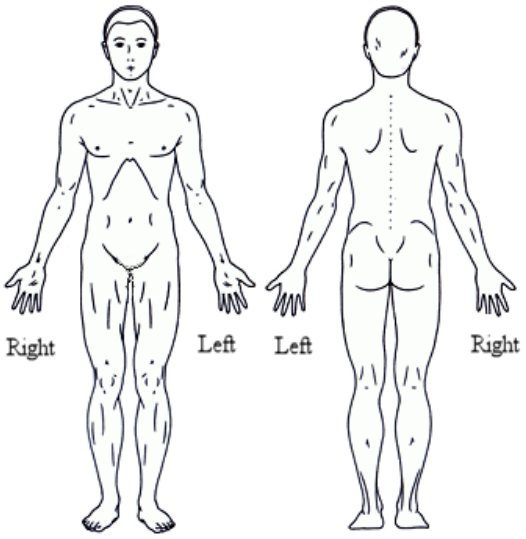
☐ Headaches	☐ Low-Back Pain	☐ Car Accident	☐ Sinus/Allergies	☐ Sleeping Problems
☐ Neck Pain	☐ Leg/Hip Pain	☐ Scoliosis	☐ Emotional Stress	☐ Work Injury
☐ Shoulder Pain	☐ Knee Pain	☐ Numbness/Tingling	☐ Digestive/Stomach	☐ Cold/Flu
☐ Mid-Back Pain	☐ Stiffness	☐ Low Energy	☐ Dizziness	☐ Pulled Muscle

Primary Complaint: (describe reason for seeking care in this office): Date Pain/Symptoms Began: / /

_____
_____

Indicate areas of pain on the chart below:

Numbness	= = =	Knot	●
Dull Ache	OOO	Burning	XXX
Sharp/Stabbing	/ / /	Pins, Needles	+ + +
Other _____	^ ^ ^		



Please rate the severity of your pain:
(low) 1 2 3 4 5 6 7 8 9 10 (high)

Was this pain/symptom caused by an accident or injury? ☐Yes ☐No
If so, please describe: _____
_____
Date of accident/injury: / / Is there a formal claim? ☐Yes ☐No
Is a third party involved (lawyer, insurance, workman's comp)? ☐Yes ☐No

Do you have a diagnosed medical condition(s)? ☐Yes ☐No
If so, please list: _____
_____

Are you currently under medical care for the pain/symptoms? ☐ Yes ☐ No
If so, name of physician/practitioner: _____

Since the onset, the pain/symptoms have been: ☐ Better ☐ Worse ☐ Same
Is this condition worse at certain times of the day/night? ☐ Yes ☐ No
If so, please describe: _____
_____

Do you have pain that shoots, radiates, or is intermittent? ☐ Yes ☐ No
If so, please describe: _____
_____

What activities worsen?

☐ Sleeping	☐ Bending
☐ Walking	☐ Reaching
☐ Running	☐ Driving
☐ Eating	☐ Stretching
☐ Other _____	

This condition is interfering with?

☐ Sleeping	☐ House chores
☐ Work	☐ Exercise
☐ Hobbies	☐ Relationships
☐ Eating	☐ Driving
☐ Other _____	

Which complimentary therapies have you experienced?					
Chiropractic Care	Yes No	If yes, date of last visit	/ /		
Nutritional Supplementation	Yes No	Acupuncture	Yes	No	
Massage Therapy	Yes No	Homeopathy	Yes	No	
Medicinal Herbs	Yes No	Other:			

What are your Health Goals?
____ Remove pain
____ Increase Energy/Stamina
____ Restore Health/Reduce Illness
____ Achieve Optimal Health

Patient History *(Please circle Yes or No for each of the following and provide commentary as necessary)*

1. Current/Past Health Habits (check □ for past use):			Patient Comment:	Practitioner's Comment (Office Use)
Drink alcohol?	□ Past	Y N	How often?	
Drink coffee?	□ Past	Y N	How often?	
Drink water?	□ Past	Y N	How much? ____ ounces per day	
Daily sweets?	□ Past	Y N	How often?	
Sugar substitutes?	□ Past	Y N	How often?	
Dieting or cleansing?	□ Past	Y N	How often?	
Smoke cigarettes?	□ Past	Y N	How often?	
Chew tobacco?	□ Past	Y N	How often?	
OTC drug use?	□ Past	Y N	How often?	
Exercise regularly?	□ Past	Y N	How often?	
Sleep irregularity?	□ Past	Y N	Hrs of sleep/night?	
Occupational stress?	□ Past	Y N	___physical ___emotional	
Relationship stress?	□ Past	Y N	___physical ___emotional	
Wear a shoe lift or orthotic?	□ Past	Y N		
Sleep position?	Indicate Position		___ Side ___ Stomach ___ Back	

2. Current/Past Health History (check □ for past use):			Patient Comment	Practitioner's Comment (Office Use)
Dental /gum problems?	□ Past	Y N		
Eye/vision problems?	□ Past	Y N		
Hearing problems?	□ Past	Y N		
Headaches?	□ Past	Y N		
Tinnitus/ringing in the ears?	□ Past	Y N		
Depression/mental illness?	□ Past	Y N	Family History Y N	
Air hunger/deep sighs?	□ Past	Y N		
TMJ/locking of the jaw?	□ Past	Y N		
Broken bones?	□ Past	Y N		
Torn ligaments?	□ Past	Y N		
Heartburn/reflux?	□ Past	Y N		
High/low blood pressure?	□ Past	Y N		
High cholesterol?	□ Past	Y N		
Diabetes?	□ Past	Y N	Family History Y N	
Hypoglycemia?	□ Past	Y N		
Asthma?	□ Past	Y N		
Allergies	□ Past	Y N		
Respiratory infections?	□ Past	Y N		
Sinus infections?	□ Past	Y N		
Heart attack?	□ Past	Y N	Family History Y N	
Stroke?	□ Past	Y N	Family History Y N	
Mono/other serious virus?	□ Past	Y N		
Cold hands/feet?	□ Past	Y N		
Weight loss/gain?	□ Past	Y N		
Hyper/Hypothyroidism?	□ Past	Y N		
Arthritis?	□ Past	Y N	Family History Y N	
Colitis/Crohn's/IBS?	□ Past	Y N		
Frequent constipation?	□ Past	Y N		
Frequent diarrhea?	□ Past	Y N		
Grind Teeth?	□ Past	Y N	Awake? Y N Sleeping? Y N	
Irregular menses?	□ Past	Y N		
Menopause?	□ Past	Y N		
Miscarriage/infertility?	□ Past	Y N	Family History Y N	
Sleep problems?	□ Past	Y N		
Cancer?	□ Past	Y N		

Category:	Please list any of details for the following:
Prescription Medications: ☐ No Rx Medications	
Over-the-counter Drugs ☐ No OTC Medications	
Allergies (food, airborne, chemical etc.) ☐ No Allergies	
Vitamins, herbs, teas, homeopathy or other natural supplements ☐ No Supplements	
Accidents and Traumas ☐ No traumas	__ Concussions/knocked unconscious __ Known head trauma
Surgeries or Medical Procedures **(last 12 months)** ☐ No Recent Surgeries	__ Gallbladder Removed
Surgeries or Medical Procedures **(> 12 months)** ☐ No Prior Surgeries	__ Gallbladder Removed

Eating Preference: ☐ Vegan ☐ Vegetarian ☐ Dairy-free ☐ Low Carb ☐ Wheat-free ☐ Gluten-free ☐ Low/No Sugar ☐ No Restriction ☐ Other Restriction _____

Additional notes from patient regarding history/health:

_____

_____

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient Signature_____ Date / / ☐ √ if signing for minor