4241 Veterans Memorial Blvd, Ste 12
Metairie, LA 70006

Phone: 504-356-6767 Fax: 504-356-6770

Patient Registration Form

Patient Name: ____ Suffix: Jr./Sr. _____
Last First Middle

Marital Status: Single Married Divorced **Gender**: Male Female

Address: ____
Street City State Zip

Phone: ____
Cell Home Work

Date of Birth: _____/ _____/ _____ **Social Security #**: ______________________________

Email:____

Occupation:____

Preferred language: English Spanish Other: ____________________

Emergency Contact: ____

Relationship to Patient:______________________________ **Phone Number**:____________________

Date of Accident:____________________

How did the accident occur: MVA Work injury Other:______________________________

Have you retained an Attorney? Yes No

Attorney Name:______________________________ Law Firm:______________________________

Address:______________________________ Phone Number:____________________

Primary Care Physician: ____
Name Address Phone #

Pharmacy: ____
Name Address Phone # / Fax #

Patient Signature:____ **Date**:______________

Parent/Guardian (if patient is a minor):____

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Name:_______________________________________ **Date**:__________________

Were you the driver? Yes No

Did the air bag deploy? Yes No

Go by ambulance Yes No

Go to ER or Urgent Care? Yes No If yes, where________

Vehicle drivable after accident? Yes No

Car deemed totaled by insurance? Yes No

Have you had Chiropractic/ Physical Therapy? Yes No Name of chiro/ PT:_______________________________

Circle which treatments you've had:

Heat Manual therapy Ultrasound Electrical stimulation/TENS
Massage Traction Other: ______________________

Did it help?

No Relief Moderate Relief Some Relief

Have you taken any medications today for pain? Yes No

If yes, please list ____

For Neck & Back Pain Only

<u>NECK PAIN</u>

How often is your pain? Constant Often Sometimes

What describes your pain?

Aching Sharp Electric Numbness
Stabbing Dull Burning Shooting

Does the neck pain radiate or travel? Yes No If yes check everywhere that it does

Left shoulder Left arm Left forearm Left hand Left fingers
Right shoulder Right arm Right forearm Right hand Right fingers

Pain scale

Rate your pain that you have **now** 0 1 2 3 4 5 6 7 8 9 10
Rate your pain when it is at its **worst** 0 1 2 3 4 5 6 7 8 9 10

Is there any muscle weakness of the arms or hands? Yes No
Are there any associated headaches with the neck pain? Yes No

<u>BACK PAIN</u>

How often is your pain? Constant Often Sometimes

What describes your pain?

Aching Sharp Electric Numbness
Stabbing Dull Burning Shooting

Does the back pain radiate or travel? Yes No If yes check everywhere that it does

Left leg Left foot
Right leg Right foot

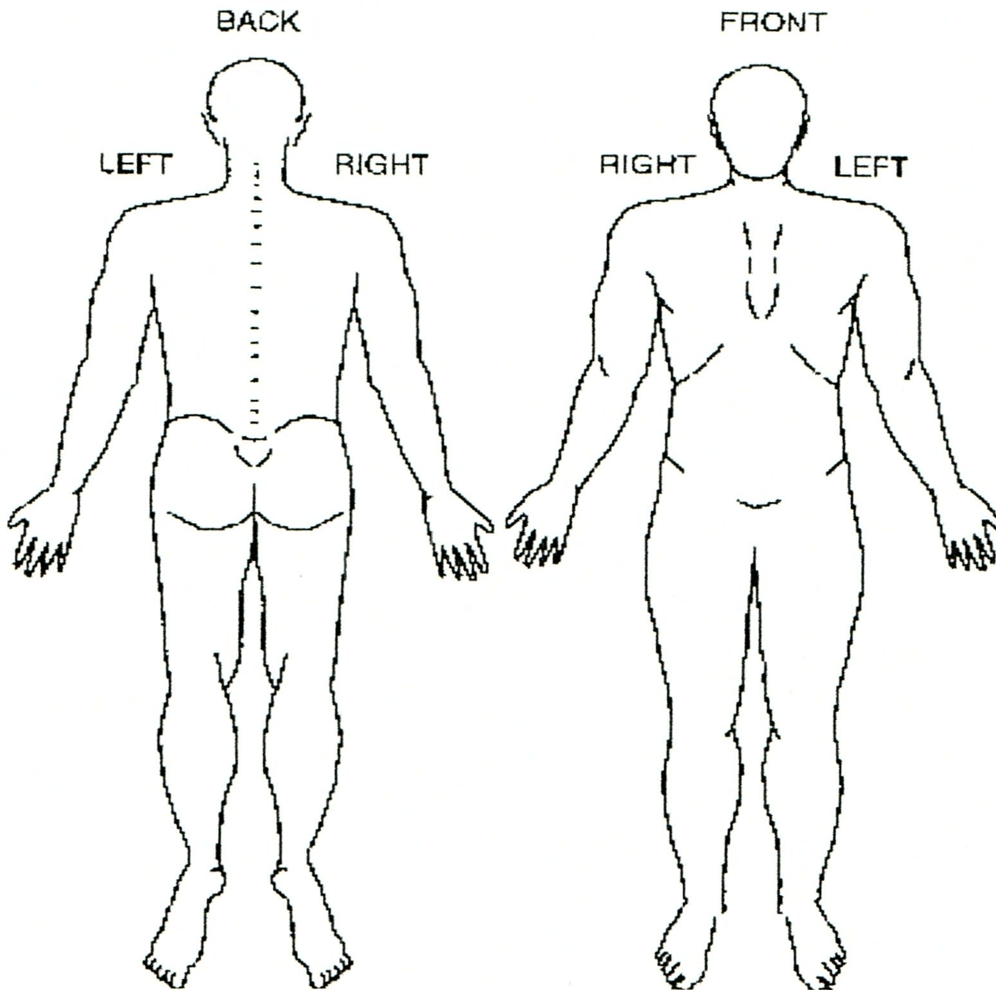
Back pain scale

Rate your pain that you have **now** 0 1 2 3 4 5 6 7 8 9 10
Rate your pain when it is at its **worst** 0 1 2 3 4 5 6 7 8 9 10

Is there any muscle weakness of the legs or feet? Yes No
Are there any associated headaches with the back pain? Yes No

Guardian CARE

PLACE AN "X" or DRAW A LINE IN THE AFFECTED AREAS WHERE YOU HAVE PAIN OR NUMBNESS



I certify that all the information given is a true assessment of my medical History.

Print Name: ______________________________ Date: ______________________

Signature: ______________________________

Guardian CARE

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Medical History

Name:______________________________________ Date:___________________

Past Medical History (Please check all that apply)

	Heart Disease		Poor Circulation		Diabetes
	Irregular Heart Beat		High Blood Pressure		Cancer (type) __________________
	Stroke		Low Blood Pressure		Emphysema
	Paralysis		Blood Transfusion		Stomach Ulcers
	Seizures		Blood Clots - Legs		Kidney Disease
	Varicose Veins		Blood Clots - Lungs		Extremity Numbness
	Asthma		Bleeding Disorder		Jaundice
	Steroid Medications		Leg Swelling		Hepatitis
	HIV or AIDS		Blood thinning Medication		Anesthesia Complications/ Problems
	Anemia		Depression		Back Pain (Severe)
	Arthritis		Alcohol Abuse		Thyroid Disorder
	Coagulopathy		Drug Abuse		Congestive Heart Failure
	COPD		Coronary Artery Disease		Emphysema
	Fibromyalgia		Hypertension		Other: _______________________

Past Surgical History ☐ **Please check box if None**

	Date	Procedure
1.		
2.		
3.		
4.		

Please List Any Current Medications and the Dosage? ☐ **Please check box if None**

	Medication	Dosage		Medication	Dosage
1.			4.		
2.			5.		
3.			6.		

Please List Any Allergies you have (Drug, Food, etc) ☐ **Please check box if None**

	Medication		
1.		3.	
2.		4.	

Please answer the following questions:

Do you take blood thinners?	☐ Yes ☐ No
Do you take Aspirin?	☐ Yes ☐ No
Do you have any metal implants?	☐ Yes ☐ No
Do you have a pacemaker?	☐ Yes ☐ No
Are you pregnant or could be pregnant?	☐ Yes ☐ No If yes, how far along are you? _________
Are you breast feeding?	☐ Yes ☐ No If yes, how long? _________

Please list any other medical conditions:

____

____

____

Patient Signature: ____ **Date** _____________

Parent/Guardian (if patient is a minor):____