Geneva Spinal Health

Registration & History

Patient Information

Patient Name: _____Address_____
City State Zip

Sex: Male☐ Female☐ Date of Birth _____

Parent/Guradian_____Address_____
City State Zip

Phone: Number Home_____ Cell_____ Work_____

E-Mail Address_____

How did you hear about Geneva Spinal Health? _____

Past Medical History

Are you pregnant? ☐Yes ☐No Due Date_____

AIDS/HIV	☐Yes ☐No	**Emphysema**	☐Yes ☐No	**Miscarriage**	☐Yes ☐No	**Scarlet Fever**	☐Yes ☐No
Alcoholism	☐Yes ☐No	**Epilepsy**	☐Yes ☐No	**Mononucleosis**	☐Yes ☐No	**Stroke**	☐Yes ☐No
Allergy Shots	☐Yes ☐No	**Fractures**	☐Yes ☐No	**Multiple Sclerosis**	☐Yes ☐No	**Suicide Attempt**	☐Yes ☐No
Anemia	☐Yes ☐No	**Glaucoma**	☐Yes ☐No	**Mumps**	☐Yes ☐No	**Thyroid Problems**	☐Yes ☐No
Anorexia	☐Yes ☐No	**Goiter**	☐Yes ☐No	**Osteoporosis**	☐Yes ☐No	**Tonsillitis**	☐Yes ☐No
Appendicitis	☐Yes ☐No	**Gonorrhea**	☐Yes ☐No	**Pacemaker**	☐Yes ☐No	**Tuberculosis**	☐Yes ☐No
Arthritis	☐Yes ☐No	**Gout**	☐Yes ☐No	**Pancreatic**	☐Yes ☐No	**Tumors, Growths**	☐Yes ☐No
Asthma	☐Yes ☐No	**Headaches**	☐Yes ☐No	**Parkinson's Disease**	☐Yes ☐No	**Typhoid Fever**	☐Yes ☐No
Bleeding Disorders	☐Yes ☐No	**Heart Disease**	☐Yes ☐No	**Pinched Nerve**	☐Yes ☐No	**Ulcers**	☐Yes ☐No
Breast Lump	☐Yes ☐No	**Hepatitis**	☐Yes ☐No	**Pneumonia**	☐Yes ☐No	**Urinary Tract Infections**	☐Yes ☐No
Bronchitis	☐Yes ☐No	**Hernia**	☐Yes ☐No	**Polio**	☐Yes ☐No	**Vaginal Infections**	☐Yes ☐No
Bulimia	☐Yes ☐No	**Herniated Disk**	☐Yes ☐No	**Prostate Problem**	☐Yes ☐No	**Venereal Disease**	☐Yes ☐No
Cancer	☐Yes ☐No	**Herpes**	☐Yes ☐No	**Prosthesis**	☐Yes ☐No	**Whooping Cough**	☐Yes ☐No
Cataracts	☐Yes ☐No	**High Blood Pressure**	☐Yes ☐No	**Psychiatric Care**	☐Yes ☐No	**Other**_____	
Chemical Dependency	☐Yes ☐No	**High Blood Cholesterol**	☐Yes ☐No	**Rheumatoid Arthritis**	☐Yes ☐No		
Chicken Pox	☐Yes ☐No	**Kidney Disease**	☐Yes ☐No	**Rheumatic Fever**	☐Yes ☐No		
Depression/ Anxiety	☐Yes ☐No	**Liver Disease**	☐Yes ☐No				
Diabetes	☐Yes ☐No	**Measles**	☐Yes ☐No				

Family History

Have your immediate family members (mother, father, sister, brother, grandparents) had any of the following:

☐**High Blood Pressure**	☐**Diabetes**	☐**Mental Illness**	☐**Other**
☐**Heart Disease**	☐**Kidney Disease**	☐**Headaches**	**Explain:**
☐**Emphysema**	☐**Back Problems**	☐**Thyroid Disease**	
☐**Seizures-Convulsions**	☐**Ulcer or Stomach Problems**	☐**Circulation Problems**	
☐**HIV Positive**	☐**Stroke**	☐**Cancer**	
☐**Asthma**	☐**Arthritis-Rheumatism**	☐**Osteoporosis**	

Injuries/Surgeries you have had	**Description**	**Date**
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

Medications	**Allergies**	**Vitamins/Herbs/Minerals**
_____	_____	_____
_____	_____	_____

Work Activity
☐**Sitting**
☐**Standing**
☐**Light Labor**
☐**Heavy Labor**

Exercise
☐**none**
☐**moderate**
☐**Daily**
☐**Heavy**

Habits
☐**Smoking** **Packs/Day**_____
☐**Alcohol** **Drinks/Week**_____
☐**Coffee/Caffeine Drinks** **Cups/Day**_____
☐**High Stress Level** **Reason**_____