NOVOCUR

1076 West Chandler Blvd, #109
Chandler, Arizona 85224
480 .786. 4644

10025 E. Dynamite Road, Suite B145
Scottsdale, AZ 85262
480. 515. 1886

Patient Registration and History Questionnaire

Name: ____ Age: _________Date of birth: _____________ Date: ___________
LAST FIRST MIDDLE

Address: ______________________________________ City: ____________________ State: _____ Zip Code: _________

Social Security #: __________________ ☐ Male ☐ Female Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children_____

Home Phone (_____) _____________________________Work Phone (_____) ____________________________________

Cell Phone (_____) ______________________________ E-mail Address: _______________________________________

Employer: _____________________________________ Spouse's Name: _______________________________________

Occupation: ___________________________________ Spouse's Employer: ____________________________________

Who referred you to this office: ____

Name & Phone # of your Primary Care Physician ______________________________ May we send correspondence to him/her regarding your treatment?
______________________________ Yes___________No__________

In case of emergency, notify______________________ Relationship: ____________ Phone (_______) ___________

Chief Complaint or Reason for Office Visit: ____

Specific Date and Time of Onset of Symptoms: ____

What makes your symptoms better? ____________________What makes your symptoms worse? __________________

What is the quality of your symptoms? (ache, burn, dull, sharp, throbbing): _____________________________________

Are your symptoms local or do they travel to another area? (If they travel, to where?) ______________________________

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% **of your waking hours**

Prior conservative care (chiropractic, physical therapy, massage, acupuncture, medication, etc):

Type of care:	Date(s):

Please list all medications and dosage:	**Frequency**	**For What Illness?**

Are you allergic to any of the following (please circle): Latex, Betadine, Procaine, Lidocaine, Traumeel

List any allergies to medications, foods or other (if none, write none): ____

____

____

Are you pregnant? ☐ Yes ☐ No
Patient Name: ________________________________ Date of Birth: ____________ Page Two History Form

Do you smoke? ☐ Yes ☐ No; How much? ___________ Do you drink alcohol? ☐ Yes ☐ No; How much? ___________

Please list all serious illness: **Month and Year**

Please list all serious surgeries: **Month and Year**

Please list all serious accidents/injuries: **Month and Year**

Please list any recent x-rays, MRI's, CAT Scans, labs or other tests: **Date** **Facility/Doctor**

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / MS	☐ Yes
Colon Disease	☐ Yes	Stroke	☐ Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Dependence	☐ Yes	AIDS	☐ Yes