MORAINE VALLEY CHIROPRACTIC CENTER **DR. LINDA LUCIENNE EHLERS**
8700 WEST 95TH STREET **HICKORY HILLS, ILLINOIS 60457** **1-708-598-9010**

REGISTRATION FORM

Patient_____
Last Name **First Name** **Initial**
Date_____ **Home/Cell Phone**_____ **Work Phone**_____
Street Address_____ **City** _____
State_Illinois _____ **Zip**_____ **E-Mail** _____
Sex M F Age_____ **BirthDate**_____ **Divorced Married Separated Single Widowed**
Whom may we thank for referring you to us?_____

SYMPTOMS

Condition/ Illness Related To An Illness Your Employment Auto Accident Other
Reason for appointment? _____
When did you first notice the symptoms? _____
Is this condition getting progressively worse? Yes No _____
What treatment have you already received for your condition? Medication Surgery Physical Therapy Other_____
Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? Yes No

HEALTH HISTORY - Check only those conditions that are applicable:

☐ AIDS/HIV	☐ Cataracts	☐ Hepatitis	☐ Osteoporosis	☐ Stroke
☐ Alcoholism	☐ Chemical/Drug Dependency	☐ Hernia	☐ Pacemaker	☐ Suicide Attempt
☐ Allergy Shots	☐ Chicken Pox	☐ Herniated Disc	☐ Parkinson's Disease	☐ Thyroid Problems
☐ Anemia	☐ Depression	☐ Herpes	☐ Pinched Nerve	☐ Tonsillitis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tuberculosis
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Polio	☐ Tumors, Growths
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Prostate Problems	☐ Typhoid Fever
☐ Asthma	☐ Fractures	☐ Measles	☐ Prosthesis	☐ Ulcers
☐ Bleeding	☐ Glaucoma	☐ Migraine Headaches	☐ Psychiatric Care	☐ Vaginal Infections
☐ Disorders	☐ Goiter	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Venereal Disease
☐ Breast Lump	☐ Gonorrhea	☐ Mononucleosis	☐ Rheumatic Fever	☐ Whooping Cough
☐ Bronchitis	☐ Gout	☐ Multiple Sclerosis	☐ Scarlet Fever	☐ Other _____
☐ Bulimia	☐ Heart Disease	☐ Mumps		
☐ Cancer				

Dates of last physical examination _____
(Women) Are you pregnant? Yes/No Nursing? Yes/No Birth Control Pills? Yes/No
List any types of surgeries which you have had and the dates which they occurred:_____
_____
Please list *all* medications you are currently taking: _____
_____
Allergies: _____

LIFESTYLE INFORMATION

What type of exercise do you perform on a daily basis? None Moderate Heavy
What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)
_____
What kind of nutritional supplements do you take (if any)? _____
Do you smoke? No/Yes How much per day? _____
How much coffee or caffeinated beverages do you consume on a daily basis? _____
-Women: When was the last time you had more than 4 drinks in one day?
Less than 3 months ago More than 3 months ago Never
-Men: When was the last time you had more than 5 drinks in one day?
Less than 3 months ago More than 3 months ago Never