

Patient Registration Form

Date _____

Name _____ Home Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____ Email _____

Date of Birth _____ | Male Female | Single Married Divorced Widowed

Social Security _____ Driver License _____

Employer _____ Occupation _____

Employer Address _____ Private Physician _____

City _____ State _____ Zip _____ Referred by _____

Emergency Contact _____ Contact Phone _____

Please circle "Y" for yes or "N" for no

Do you experience vertigo (dizziness)?	Y	N
Do you pass out easily (faint, lose consciousness)?	Y	N
Do you have double vision or have you lost sight in one eye?	Y	N
Do you have any slurred speech or difficulty speaking?	Y	N
Do you have or have you ever had difficulty arranging words properly?	Y	N
Have you experienced any difficulty walking, with coordination or falling to one side?	Y	N
Do you experience nausea or vomiting?	Y	N
Do you have numbness on one side of your face or body?	Y	N
Do you have any visual disturbances or rapid eye movement?	Y	N
Do you get headaches or experience head pain unlike any you have had before?	Y	N
Do you experience headaches for hours or days?	Y	N
Do you have a history of stroke in your family?	Y	N
Do you have chest pain?	Y	N
Have you experienced any change in bowel or bladder habits?	Y	N
Do you have a sore that won't heal?	Y	N
Do you have any unusual bleeding or discharge?	Y	N
Do you have indigestion or difficulty swallowing?	Y	N
Have you noticed any change in any wart or mole?	Y	N
Do you have a nagging cough or hoarseness?	Y	N
Do you have night sweats?	Y	N
Do you have pain in your neck, jaw or face?	Y	N
Do you have a drooping eyelid or have you experienced any change in your pupils?	Y	N
Do you have any ringing in your ears?	Y	N
Do you take birth control pills?	Y	N
Are you currently pregnant?	Y	N
What prescription medication are you taking if any?		
<input type="radio"/> High blood pressure medication	<input type="radio"/> Herb, vitamins or over the counter products _____	
<input type="radio"/> Blood thinners	<input type="radio"/> Other _____	

