

(ki''ro-prak'tik)

19 Mile & Schoenherr
(586) 247-0100

Date: _____

Confidential patient health record

Email _____

Cell Phone () _____

Name _____ Home Phone () _____

Address _____ City _____ Zip _____

Age _____ Birthdate _____ Marital Status Single Married Widow(er) Divorced How many children? _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Wife or Husband _____ Occupation _____

Employer _____ Office Phone _____

Other nearest relative _____ Phone _____

Referred by _____ If insured, name of company _____

Present family doctor _____ Policy Holders Name _____ Birthdate ____ / ____ / ____

Date of last physical examination _____ By Doctor _____

Permission to contact your doctor? Yes No

List present complaints and duration:

1. _____

2. _____

3. _____

Remarks _____

For Accidental injuries:

Auto Work Home Leisure Sports

List other doctors consulted for this condition(s):

Name _____ When consulted _____

Diagnosis _____ Treatment _____

Results _____

Name _____ When consulted _____

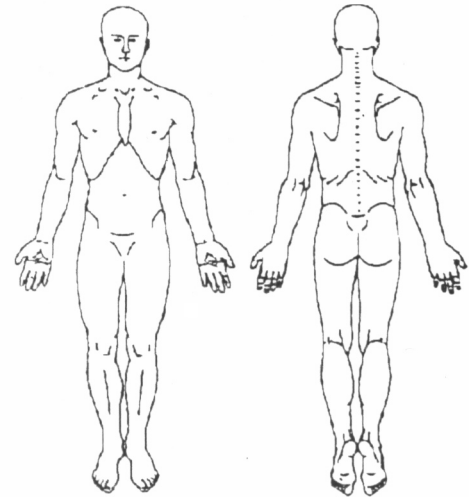
Diagnosis _____ Treatment _____

Results _____

Have you ever treated with a chiropractor in the past? _____

Name _____ Results _____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol to mark all affected areas.



Numbness Burning Stabbing Pins & Needles
^^^ XXXX /// OOO

What surgery have you had:

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Type _____ When _____ Doctor _____

Remarks _____

List serious accidents and falls: (auto, work, home, leisure, sports, other - circle one)

What _____ When _____

What _____ When _____

Remarks _____

List fractures:

What _____ When _____

What _____ When _____

Remarks _____

List medications and/or diet supplements you take:

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

What _____ Frequency _____ Doctor _____

Remarks _____

Check any of the following diseases you have or have had:

- | | | | |
|-----------------|----------------|--------------|-------------------|
| Appendicitis | Malaria | Chicken Pox | Alcoholism |
| Scarlet fever | Tuberculosis | Diabetes | Veneral infection |
| Diphtheria | Whooping cough | Cancer | Arthritis |
| Typhoid fever | Anemia | Heart Attack | Epilepsy |
| Pneumonia | Measles | Goiter | Mental disorder |
| Rheumatic fever | Mumps | Influenza | Lumbago |
| Polio | Small pox | Pleurisy | Eczema |

Are you pregnant? Yes No Maybe

Circle current conditions...Check former conditions:

Musculo-skeletal

Headache
Neck/shoulder/arm pain
Back pain
Low back/leg pain
Arthritis
Nervousness/irritability/tension
Stiff neck
Backache
Swollen joints
Tremors
Painful tailbone
Hernia
Spinal curvature (Scoliosis)
Faulty posture

Cardio-vascular

Rapid beating heart
Slow beating heart
High blood pressure
Low blood pressure
Pain over heart
Previous heart attack
Hardening of arteries
Swelling of ankles
Poor circulation
Paralytic stroke

Respiratory

Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficult breathing
Asthma

General Symptoms

Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Loss of sleep
Fatigue
Nervousness
Loss of weight
Numbness of pain in arms, hands or legs
Allergy
Neuralgia

Skin

Skin eruptions
Itching
Bruises easily
Dryness
Boils
Varicose veins
Sensitive skin
Hives or allergy
Shingles

Distorted Senses

Sight
Hearing
Touch
Taste
Smell
Eye pain
Earache
Ear noises
Sore throat
Hoarseness
Hay fever

Gastrointestinal

Poor Appetite
Excessive hunger
Belching or gas
Nausea
Vomiting
Vomiting of blood
Pain over stomach
Distension of abdomen
Constipation
Diarrhea
Colon trouble
Hemorrhoids
Liver trouble
Gall bladder trouble

Genitourinary

Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection or stones
Bed wetting
Inability to control urine
Prostate trouble
Bladder infection

Female

Painful menstrual periods
Excessive flow
Hot flashes
Irregular cycle
Cramps or back ache
Previous miscarriage
Congested breast
Lumps in breast
Menopausal symptoms

How will you be paying for your visit today? Cash Check Visa MC Discover

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. **However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.**

Patient's Signature _____ SS# _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

Information taken by: _____

Date: _____

Name: _____

**FILL OUT THE FOLLOWING FORM FOR
WORKMANS COMPENSATION CLAIM OR AUTO ACCIDENT ONLY**

Date of accident _____ Hour _____ AM ___ PM ___ Location _____

How did accident occur? Auto collision On-the-job injury Other

Please describe the circumstances _____

Did you report the injury to your foreman or employer? YES NO

Did he (they) recommend care at our office? YES NO

If auto accident, were you Driver Passenger Pedestrian

If auto collision, were you struck from Behind Right Side Left Side Front Auto Was Parked

Did your car strike the other(s) involved? YES NO; Or did other car strike yours? YES NO Undetermined

As a result of the accident, were traffic citations issued to you? YES NO; To the driver of the other car? YES NO

To the driver of your car? YES NO

List the extent of the injuries as you know them _____

Did you require post-accident hospitalization? YES NO

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Face flushed | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Hands cold |
| <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Ears ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms other than above _____

Have you lost any days of work? _____ Dates _____

Insurance companies involved?

My company _____

Company of person responsible for injuries _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? YES NO

Do you have an attorney that has advised you in this case? YES NO

Attorney's name _____ Address _____ Telephone _____