(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:

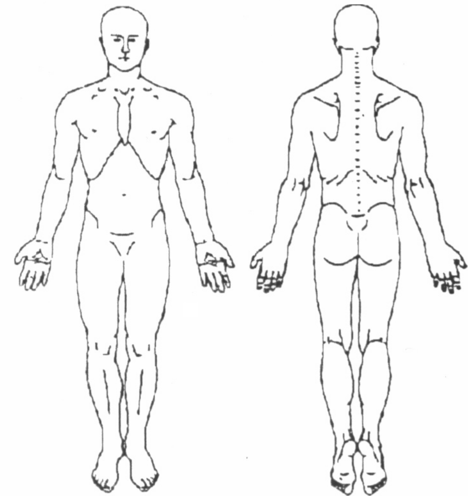
1. ____
____

2. ____
____

3. ____
____

Remarks ____
____
____
____
____

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	////	oooo

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 ___________________________

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
Paralysic 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. Futhermore, 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 m 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 immediateley 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

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

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 __________

Patient Name: Date:

Print this page and fill in the information before your appointment. You will want to keep a copy for your records.

Allergies to Medications	
Use the chart below to list all medication, both prescription and nonprescription, you are allergic to.	
Medication Name	**Type of reaction, such as rash of breathing difficulties**

Prescription Medications				
Use the chart below to list all the brand-name and generic prescription medications you currently take. Be sure to fill in all the information for each medication. The amount of medication in each pill appears on the prescription label in milligrams (mg). This is called the dose or strength. the label on liquids and shots lists the dose too.				
Medication Name	**Prescribing Doctor**	**Reason taking medication**	**Dose (ex:1tsp)**	**How often? (ex; 3X/day)**

Patient Name: Date:

Nonprescription Medication, Vitamins and Supplements			
List all those you take occasionally, such as aspirin for headache, as well as those you take every day, such as multivitamin or nutritional supplement. Include any herbs or alternative medicines that you take.			
Name	**Reason for Taking**	**Dose**	**How often?**