Central Michigan
Family Chiropractic Clinic

1105 s. Mission st. Mt.Pleasant, MI 48858 989-779-2225

Date: _____

I.D. NO._____

Confidential Patient Health Record

PERSONAL HISTORY

Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Birthdate: _____ Age: _____ Sex: _____
Email Address: _____ Drivers Lic. #: _____
Business/Employer: _____ Type of Work: _____
Business Phone: _____ Name of Spouse: _____ # of Children ____
Whom may we thank for referring you to us: _____ Relationship: _____
Whom may we contact in case of an emergency: _____ Phone: _____
I will be paying today by: Cash _____ Check _____ Credit Card _____
Health Insurance Co. (Name) _____ Insured _____
Social Security # _____ Employer _____

CURRENT HEALTH CONDITION

Major Complaint, Symptom, Area(s) of Pain: _____
_____
Other Doctors Seen For This Condition: ( ) No ( ) Yes Who? _____
Type of Treatment Rendered: _____ Results: _____
When Did This Condition Begin: _____
Has This Condition Occurred Before? ( ) No ( ) Yes When? _____
Is Condition: ( ) Job Related ( ) Auto Related ( ) Home Injury ( ) Other
Date of Accident: _____ Time of Accident: _____
How Did This Happen? _____
Have You Made a Report Of Your Accident To Your Employer: ( ) No ( ) Yes
Drugs You Now Take: (List) _____

PAST HEALTH HISTORY

Major Surgery/Operations - Please Check And Date:
( ) _____ Appendectomy ( ) _____ Tonsillectomy ( ) _____ Gall Bladder
( ) _____ Hernia ( ) _____ Back Surgery ( ) _____ Broken Bones ( ) Other: _____
Major Accidents Or Falls: _____
_____
Hospitalization (Other Than Above): _____
_____
Previous Chiropractic Care: ( ) None ( ) Doctor's Name and Approx. Date of Last Visit:
_____
Does Anyone In Your Family Have The Same Or Similar Condition? ( ) No ( ) Yes Who?
_____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan, and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST SIX MONTHS:

General Symptoms

____ 784.0 Headache
____ 780.6 Fever
____ 780.9 Chills
____ 780.8 Night Sweats
____ 780.2 Fainting
____ 780.4 Dizziness
____ 780.3 Convulsions
____ 780.52 Loss of Sleep
____ 780.7 Fatigue
____ 799.2 Nervousness
____ 783 Loss of Weight
____ 782 Numbness or Pain in arms/legs/hands
____ 995.3 Allergy (What?)
____ 786.09 Wheezing
____ 729.2 Neuralgia

Gastro-intestinal

____ 783 Poor Appetite
____ 536.8 Poor Digestion
____ 994.2 Excessive Hunger
____ 787.3 Belching or Gas
____ 787 Nausea
____ 787 Vomiting
____ 578 Vomiting Blood
____ 536.8 Pain Over Stomach
____ 564 Constipation
____ 558.9 Diarrhea
____ 789 Colon Trouble
____ 455.6 Hemorrhoids (Piles)
____ 785.1 Liver Trouble
____ 782.4 Jaundice
____ 575.9 Gall Bladder Trouble

Eye ear nose throat

____ 368.9 Poor Vision
____ 378.9 Crossed Eyes
____ 379.91 Pain in Eyes
____ 389.9 Deafness
____ 388.70 Earache
____ 388.30 Ear Noises
____ 388.60 Ear Discharges
____ 478.1 Nasal Obstruction
____ 784.7 Nose Bleeds
____ 462 Sore Throat
____ 784.49 Hoarseness
____ 477.9 Hay Fever
____ 493.9 Asthma
____ 460 Frequent Colds
____ 240.9 Enlarged Thyroid
____ 463 Tonsillitis
____ 686.9 Sinus Trouble

Respiratory

____ 786.2 Chronic Cough
____ 786.3 Spitting Blood
____ 933.1 Spitting Phlegm
____ 786.5 Chest Pain
____ 786.09 Difficulty Breathing

Genito-urinary

____ 788.3 Frequent Urination
____ 788.1 Painful Urination
____ 599.7 Blood in Urine
____ 592 Kidney Infection
____ 788.3 Bed Wetting
____ 788.1 Inability to Control Urine
____ 601.9 Prostate Trouble

Muscle and Joints

____ Weakness
____ Twitching
____ 847 Stiff Neck
____ 722.10 Backache
____ 719 Swollen Joints
____ 781 Tremors
____ 729.5 Foot Troubles
____ 724.9 Painful Tail Bone
____ 724.5 Pain Between Shoulders
____ 553.9 Hernia
____ 737.3 Spinal Curvature

Cardio-Vascular

____ 783 Rapid Heart
____ 427.89 Slow Heart
____ 401.9 High Blood Pressure
____ 458.9 Low Blood Pressure
____ 786.51 Pain Over Heart
____ 438 Prev. Heart Trouble
____ 719.07 Swelling Ankles
____ 459.9 Poor Circulation Varicose Veins
____ 436 Strokes

Skin or Allergies

____ 368.9 Skin Eruptions
____ 698.9 Itching
____ 287.8 Bruising Easily
____ 701.1 Dryness Boils
____ 782 Sensitive Skin
____ 708.9 Hives or Allergy
____ 692.9 Eczema
____ Medicines

For Women Only

____ 786.2 Painful Periods
____ 626.2 Excessive Flow
____ 626.4 Irregular Cycles
____ 627.2 Hot Flashes
____ 625.3 Cramps or Backache
____ 634.9 Miscarriage

Are You Pregnant?
☐ Yes ☐ No
Date of last period: _____

Habits

____ Smoking ___ pks/day
____ Drinking ___ alcohol
____ Coffee ___ cups/day

Exercise

____ None
____ Moderate
____ Daily

Family History

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother No. of ___	☐	☐	☐	☐	☐
Sister No. of ___	☐	☐	☐	☐	☐

Family Physician: _____ **Address:** _____

Have you had any of the following diseases?

____ 541 Appendicitis
____ 541 Pneumonia
____ 541 Rheumatic Fever
____ 541 Polio
____ 341 Tuberculosis
____ 541 Whooping Cough
____ 285.9 Anemia
____ 285.9 Measles
____ 285.9 Mumps
____ 285.9 Chicken Pox
____ 285.9 Diabetes
____ 285.9 Cancer
____ 429.9 Heart Disease
____ 429.9 Goiter
____ 429.9 Influenza
____ 429.9 Pleurisy
____ 429.9 Alcoholism
____ 429.9 Venereal infection
____ 716.9 Arthritis
____ 716.9 Epilepsy
____ 716.9 Mental disorder
____ 716.9 Lumbago
____ 716.9 Eczema

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 on 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 X _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____