Central Michigan Family Chiropractic Clinic

1112 E. Broomfield, Mt. Pleasant, MI 48858 989-779-2225

Date: ____________________

PERSONAL HISTORY

Name: ______________________________ Address: ____________________________ **APT #**___
City: ______________________________ State: ____________________ Zip: ______________
Home Phone: ________________________ Birthdate: ____________ Age: ______ Sex: _____
Cell Phone: ________________________ Social Security #: ______________________________
Employment status (circle one): full-time part-time self retired not employed/unemployed
Business/Employer: ___________________ Type of Work: __________________________
Business Phone: ______________ **Name of Spouse**: ____________________ # of Children ____
Student status (circle one): full-time part-time non-student
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 __________
Insurance (Name) ________________ **Insured (name of policy holder):** ____________________
Insured birth date: ________________ **Insured SSN:** ______________________________
Relationship to Insured: ___________ **Insured 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? ______________________
Date of Accident/Trauma: __________________________ Time of Accident/Trauma: __________
How Did This Happen? ____
Drugs You Now Take: (List) ____

PAST HEALTH HISTORY

Major Surgery/Operations - Please Check And Date of Occurrence:
( ) _____ 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 affect 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 THREE MONTHS:

General Symptoms
____ Headache
____ Fever
____ Chills
____ Night Sweats
____ Fainting
____ Dizziness
____ Convulsions
____ Loss of Sleep
____ Fatigue
____ Nervousness
____ Loss of Weight
____ Numbness or Pain in arms/legs/hands
____ Allergy (What?)
____ Wheezing
____ Neuralgia

Gastro-intestinal
____ Poor Appetite
____ Poor Digestion
____ Excessive Hunger
____ Belching or Gas
____ Nausea
____ Vomiting
____ Vomiting Blood
____ Pain Over Stomach
____ Constipation
____ Diarrhea
____ Colon Trouble
____ Liver Trouble
____ Jaundice
____ Gall Bladder Trouble

Eye ear nose throat
____ Poor Vision
____ Crossed Eyes
____ Pain in Eyes
____ Deafness
____ Earache
____ Ear Noises
____ Ear Discharges
____ Nasal Obstruction
____ Nose Bleeds
____ Sore Throat
____ Hoarseness
____ Hay Fever
____ Asthma
____ Frequent Colds
____ Enlarged Thyroid
____ Tonsillitis
____ Sinus Trouble

Respiratory
____ Chronic Cough
____ Spitting Blood
____ Spitting Phlegm
____ Chest Pain
____ Difficulty Breathing

Genito-urinary
____ Frequent Urination
____ Painful Urination
____ Blood in Urine
____ Kidney Infection
____ Bed Wetting
____ Inability to Control Urine
____ Prostate Trouble

Muscle and Joints
____ Weakness
____ Twitching
____ Stiff Neck
____ Backache
____ Swollen Joints
____ Tremors
____ Foot Troubles
____ Painful Tail Bone
____ Pain Between Shoulders
____ Hernia
____ Spinal Curvature

Cardio-Vascular
____ Rapid Heart
____ Slow Heart
____ High Blood Pressure
____ Low Blood Pressure
____ Pain Over Heart
____ Prev. Heart Trouble
____ Swelling Ankles
____ Poor Circulation
____ Varicose Veins
____ Strokes

Skin or Allergies
____ Skin Eruptions
____ Itching
____ Bruising Easily
____ Dryness
____ Boils
____ Sensitive Skin
____ Hives or Allergy
____ Eczema
____ Medicines

For Women Only
____ Painful Periods
____ Excessive Flow
____ Irregular Cycles
____ Hot Flashes
____ Cramps or Backache
____ Miscarriage

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

Habits
____ Smoking ___ pks/day
____ Alcohol ___ per/day
____ Coffee ___ cups/day

Exercise
____ None
____ Moderate
____ Daily

Family History

Who?	Diabetes	Heart	Kidney	Cancer	Back
__________	☐	☐	☐	☐	☐
__________	☐	☐	☐	☐	☐
__________	☐	☐	☐	☐	☐
__________	☐	☐	☐	☐	☐

Family Physician: ______________________________ **Address:** ______________________________

Have you had any of the following diseases?
____ Appendicitis
____ Pneumonia
____ Rheumatic Fever
____ Polio
____ Tuberculosis
____ Whooping Cough
____ Anemia
____ Measles
____ Mumps
____ Chicken Pox
____ Diabetes
____ Cancer
____ Heart Disease
____ Goiter
____ Influenza
____ Pleurisy
____ Alcoholism
____ Venereal infection
____ Arthritis
____ Epilepsy
____ Mental disorder
____ Lumbago
____ 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 ____________