GET WELL
CHIROPRACTIC

Case Number

Today's Date

CA DC

Tell Us About You

Title:_____ First:_____ MI:___ Last:_____

Nickname:_____ Birth date:_____ Age:_____ Sex: ❒ Male ❒ Female

Current address:_____

City:_____ State:_____ Zip:_____ SS #:____-____-_____

Primary Tel:_____-_____-_____ H / W / C Alt. Tel:_____-_____-_____ H / W / C

Email:_____ In which format do you prefer appointment reminders?

❒ Text message—provider:_____ ❒ Email (above)

Whom may we thank for referring you?_____

Marital status: ❒ Single ❒ Divorced ❒ Widowed ❒ Married to:_____

# of children:_____ Ages of children:_____

Employment status: ❒ Full-time ❒ Part-time ❒ Not employed ❒ Self ❒ Retired ❒ Military

Occupation:_____ Employer:_____

Student: ❒ No ❒ Full-time ❒ Part-time School name:_____

Alternate address:_____

City:_____ State:_____ Zip:_____ Parents/Other:_____

Emergency Contact:_____ Phone:_____-_____-_____

Emergency contact is your: ❒ Spouse/partner ❒ Parent ❒ Other:_____

Tell Us Why You're Here

What is the primary reason for your visit? _____

_____

Is this due to a: ❒ Automobile accident ❒ Work-related injury ❒ Personal injury case ❒ None

When did your pain/symptoms begin (include date if possible)?_____

The overall severity of your complaints/concerns is:

❒ Mild ❒ Mild to moderate ❒ Moderate ❒ Moderately severe ❒ Severe

The overall frequency is: ❒ Occasional ❒ Intermittent ❒ Frequent ❒ Constant

On a scale of 0 to 10, how would you rate your pain/symptoms today? (please circle a number below)

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible

If your symptoms change, when are they worse: ❒ Morning ❒ Afternoon ❒ Evening ❒ Night ❒ NA

Are your symptoms/pain getting: ❒ Better ❒ Worse ❒ Staying the same

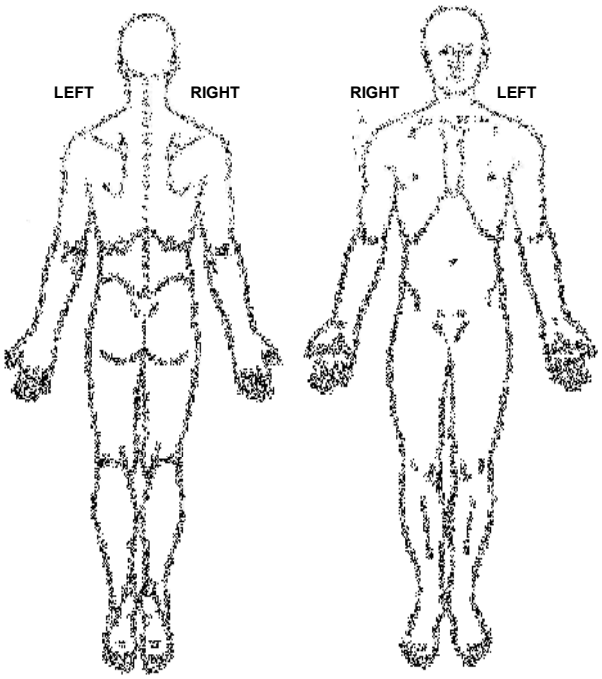
Have you had recent treatment for this condition? ❒ No ❒ Yes—please list dates and doctors:

_____

Have you had the same or similar problems in the past? ❒ No ❒ Yes—When:_____

Use the following key to mark your complaints on the diagram at the right:

Pain = **P**	Numbness = **N**	Weakness = **W**
Soreness = **O**	Stiffness = **X**	Swelling = **S**
Burning = **B**	Tingling = **T**	



If your complaints include pain, how would you describe it? (please check all that apply):

❒ Aching ❒ Burning ❒ Dull ❒ Sharp ❒ Shooting

❒ Stabbing ❒ Throbbing ❒ Other:_____

Since your symptoms began, have you noticed any function changes: ❒ Bowel ❒ Bladder ❒ Sexual ❒ No Changes

Do work activities aggravate your present complaints?

❒ Yes ❒ No ❒ NA

How often does your job involve lifting? ❒ Never ❒ Occasionally ❒ Frequently ❒ Constantly

Other job requirements (please check all that apply): ❒ Bending ❒ Carrying ❒ Stooping

❒ Twisting ❒ Turning ❒ Walking ❒ Other:_____

What is your primary work position? ❒ Seated ❒ Standing ❒ Other:_____

Mandatory Electronic Health Records

In compliance with federal government requirements for the EHR program.

Preferred language: ❒ English ❒ Chinese ❒ French ❒ German ❒ Italian ❒ Japanese

❒ Korean ❒ Polish ❒ Portuguese ❒ Russian ❒ Spanish ❒ Tagalog ❒ Vietnamese

Ethnicity: ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Declined ❒ Unknown

Race: ❒ American Indian or Alaska Native ❒ Asian ❒ Black or African American

❒ Native Hawaiian or Other Pacific Islander ❒ White ❒ Declined ❒ Unknown

Smoking status: ❒ Never smoked ❒ Former smoker ❒ Current smoker—how often:_____

Your Activities of Daily Living

Please indicate which activities of daily living are compromised by your current state of health:

- ❒ Walking
- ❒ Sitting
- ❒ Climbing stairs
- ❒ Chewing
- ❒ Kneeling
- ❒ Sleeping
- ❒ Standing
- ❒ Lifting children
- ❒ Reading
- ❒ Playing instrument
- ❒ Using telephone
- ❒ Running
- ❒ Bending
- ❒ Lying in bed
- ❒ Using computer
- ❒ Exercising
- ❒ Sitting in recliner
- ❒ Sports
- ❒ Swimming
- ❒ Recreational activities
- ❒ Getting into/out of an automobile
- ❒ Driving a car
- ❒ Riding in a car
- ❒ Other travel
- ❒ Sewing or crafts
- ❒ Doing laundry
- ❒ Making beds
- ❒ Vacuuming
- ❒ Washing dishes
- ❒ Ironing
- ❒ Carrying groceries
- ❒ Caring for pets
- ❒ Cooking
- ❒ Mowing lawn
- ❒ Raking leaves
- ❒ Gardening
- ❒ Shoveling snow
- ❒ Combing hair
- ❒ Shaving
- ❒ In/out of bathtub
- ❒ Brushing teeth
- ❒ _____
- ❒ _____
- ❒ **None apply**

Please mark whether you NOW HAVE (❍) or had IN THE PAST (❒) any of the following conditions/illnesses:

NOW HAVE / IN THE PAST		
❍ ❒ Allergies	❍ ❒ Sinus Trouble	❍ ❒ Erectile Dysfunction
❍ ❒ Hay Fever	❍ ❒ Asthma	❍ ❒ Fertility Problems
❍ ❒ Fatigue or Weakness	❍ ❒ Wheezing	❍ ❒ Excessive Thirst
❍ ❒ Night Sweats	❍ ❒ Chronic Cough	❍ ❒ Thyroid Trouble
❍ ❒ Unexpected Weight Change	❍ ❒ Shortness of Breath	❍ ❒ Anxiety or Nervousness
❍ ❒ Jaw Pain/TMJ	❍ ❒ Chest Pain or Pressure	❍ ❒ Mood Swings or Irritability
❍ ❒ Sleeping Problems	❍ ❒ Heart Trouble	❍ ❒ Mental or Emotional Difficulty
❍ ❒ Skin Problems	❍ ❒ High Blood Pressure	❍ ❒ Depression
❍ ❒ Loss of Balance	❍ ❒ Low Blood Pressure	❍ ❒ Arthritis
❍ ❒ Dizziness or Lightheadedness	❍ ❒ Cold Hands or Feet	❍ ❒ Bone Fracture
❍ ❒ Vertigo	❍ ❒ Abdominal Pain	❍ ❒ Dislocated Joints
❍ ❒ Fainting	❍ ❒ Indigestion / Upset Stomach	❍ ❒ Autoimmune Disease
❍ ❒ Headaches	❍ ❒ Excess Gas	❍ ❒ Cancer
❍ ❒ Seizures	❍ ❒ Heartburn	❍ ❒ Diabetes
❍ ❒ Loss of Memory	❍ ❒ Constipation	❍ ❒ Fibromyalgia
❍ ❒ Vision Trouble	❍ ❒ Diarrhea	❍ ❒ Multiple Sclerosis
❍ ❒ Hearing Trouble	❍ ❒ Nausea or Vomiting	❍ ❒ Rheumatic Fever
❍ ❒ Ear Infections	❍ ❒ Bedwetting	❍ ❒ Tuberculosis
❍ ❒ Ringing or Buzzing in Ears	❍ ❒ Urinary Pain or Frequency	❍ ❒ Other:_____
❍ ❒ Loss of Smell	❍ ❒ Kidney or Bladder Trouble	❍ ❒ **No Conditions/Illnesses**
❍ ❒ Loss of Taste	❍ ❒ Blood in Urine or Stool	
❍ ❒ Difficulty Swallowing	❍ ❒ Menstrual Problems or Pain	
❍ ❒ Difficulty Speaking	❍ ❒ Prostate Trouble	

Additional information and/or description:_____

_____

_____

Sickness, Injury and Accident History

***Include DATES, DESCRIPTIONS and specify (R)ight side, (L)eft side or (B)ilaterally as applicable.**

*Accidents (include automobile, work-related, personal injury, slip and fall, or any serious injury):_____

*Prior illnesses (other than colds and flu):_____

*Surgeries and hospitalizations:_____

Are you currently taking ANY over-the-counter medication: ❒ No ❒ Yes—list name and for what condition.

Are you currently taking ANY prescription medication: ❒ No ❒ Yes—list name and for what condition.

Remember to list ALL drugs including: aspirin, antibiotics, insulin, birth control pills, blood pressure pills, etc.

DRUG	**CONDITION**	**DOSAGE and FREQUENCY** (e.g. 5mg once per day)

Do you have any drug allergies? ❒ No ❒ Yes—describe:_____

Are you currently taking any vitamins or nutritional supplements: ❒ No ❒ Yes—please list with dosages:

Tell Us About Your Family Health History

Relative	**Illnesses**	**Age**	**Cause of death**
Mother			
Father			
Sister 1			
Sister 2			
Brother 1			
Brother 2			

Your Lifestyle

Which is your dominant hand: ❒ Left ❒ Right ❒ Ambidextrous

Which of the following best describes your stress level: ❒ None ❒ Minimal ❒ Moderate ❒ Extreme

Do you exercise? ❒ No ❒ Yes—How often:_____

How many caffeinated drinks do you consume:_____ per day

How many alcoholic drinks do you consume:_____ per week

Using a scale from 0 to 10, where 0 equals "awful" and 10 equals "amazing" (please circle):

How would you rate your overall health? 0 1 2 3 4 5 6 7 8 9 10

Have you ever been to a doctor of chiropractic before? ❒ No ❒ Yes—How long ago?_____

Name of prior DC:_____ City/State:_____

Do you see a medical doctor or osteopath? ❒ No ❒ Yes—Date of last visit:_____

Name of MD:_____ City/State:_____

Would you like us to send your medical doctor a report from your chiropractic examination? ❒ Yes ❒ No

WOMEN ONLY: To your knowledge are you pregnant? ❒ No ❒ Yes—Due date:_____

If no, are you currently trying to conceive? ❒ No ❒ Yes

Communication is Key to a Positive Relationship

Is there anything else you would like us to know? ❒ No ❒ Yes—_____

_____

To help us ensure clarity of communication, please initial the following:

_____ I acknowledge that I was presented with a copy of the Notice of Privacy Practices on my initial visit which describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Get Well Chiropractic.
Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices is on display in the reception room and on Get Well Chiropractic's website at **www.getwellnorthville.com**.
We encourage you to read it in full. You may obtain additional copies of our most current notice by requesting it from our privacy official, Jenni Gowing. If you have any questions regarding this notice of our health information privacy policies, please contact Jenni Gowing, our privacy official.

_____ Get Well Chiropractic may send me birthday cards and holiday greetings.

_____ Get Well Chiropractic may send me personal correspondence (notification of special events, closures, special offers, referral gifts, etc.)

_____ To the best of my knowledge the questions on this form have been accurately answered.
I understand that providing incorrect or incomplete information can be detrimental to my health.
It is my responsibility to inform Get Well Chiropractic of any changes in my health status.

Name of Patient: _____ Date:_____

Personal Representative: _____ Relationship:_____

Signature:_____ Witness:_____