



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

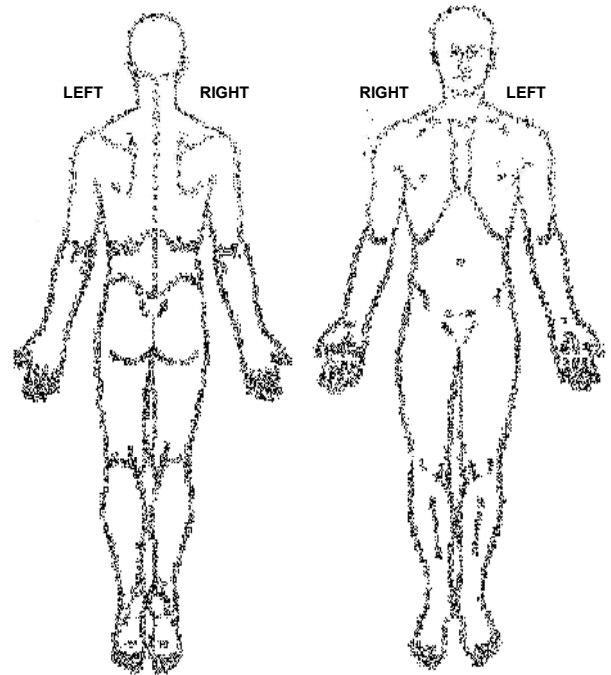
Have you had recent treatment for this condition? No Yes—please list dates and doctors:

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

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: _____

What makes your problem better? (Check all that apply)

- Nothing Standing Movement/Exercise
 Sitting Lying Down Inactivity

What makes your problem worse? (Check all that apply)

- Nothing Standing Movement/Exercise Sitting Lying Down Inactivity

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:

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

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

- | | | |
|---|---|---|
| <p>NOW HAVE
IN THE PAST</p> <ul style="list-style-type: none"> ○ ☐ Allergies ○ ☐ Hay Fever ○ ☐ Fatigue or Weakness ○ ☐ Night Sweats ○ ☐ Unexpected Weight Change ○ ☐ Jaw Pain/TMJ ○ ☐ Sleeping Problems ○ ☐ Skin Problems ○ ☐ Loss of Balance ○ ☐ Dizziness or Lightheadedness ○ ☐ Vertigo ○ ☐ Fainting ○ ☐ Headaches ○ ☐ Seizures ○ ☐ Loss of Memory ○ ☐ Vision Trouble ○ ☐ Hearing Trouble ○ ☐ Ear Infections ○ ☐ Ringing or Buzzing in Ears ○ ☐ Loss of Smell or Taste ○ ☐ Difficulty Swallowing ○ ☐ Difficulty Speaking ○ ☐ Weight Issues | <p>NOW HAVE
IN THE PAST</p> <ul style="list-style-type: none"> ○ ☐ Sinus Trouble ○ ☐ Asthma ○ ☐ Wheezing ○ ☐ Chronic Cough ○ ☐ Shortness of Breath ○ ☐ Chest Pain or Pressure ○ ☐ Heart Trouble ○ ☐ High Blood Pressure ○ ☐ Low Blood Pressure ○ ☐ Cold Hands or Feet ○ ☐ Abdominal Pain ○ ☐ Indigestion / Upset Stomach ○ ☐ Excess Gas ○ ☐ Heartburn ○ ☐ Constipation ○ ☐ Diarrhea ○ ☐ Nausea or Vomiting ○ ☐ Bedwetting ○ ☐ Urinary Pain or Frequency ○ ☐ Kidney or Bladder Trouble ○ ☐ Blood in Urine or Stool ○ ☐ Menstrual Problems or Pain ○ ☐ Prostate Trouble | <p>NOW HAVE
IN THE PAST</p> <ul style="list-style-type: none"> ○ ☐ Erectile Dysfunction ○ ☐ Fertility Problems ○ ☐ Excessive Thirst ○ ☐ Thyroid Trouble ○ ☐ Anxiety or Nervousness ○ ☐ Mood Swings or Irritability ○ ☐ Mental or Emotional Difficulty ○ ☐ Depression ○ ☐ Arthritis ○ ☐ Bone Fracture ○ ☐ Dislocated Joints ○ ☐ Autoimmune Disease ○ ☐ Cancer ○ ☐ Diabetes ○ ☐ Fibromyalgia ○ ☐ Multiple Sclerosis ○ ☐ Rheumatic Fever ○ ☐ Tuberculosis ○ ☐ Other: _____ ○ ☐ No Conditions/Illnesses |
|---|---|---|

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: _____

Have you had any organs or body parts surgically removed? No Yes—list surgery and dates:

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

DRUG

CONDITION

Your Lifestyle

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

Do you smoke? No Yes—How much: _____

Do you exercise? No Yes—How often: _____

How many caffeinated drinks do you consume: _____ per day

How many alcoholic drinks do you consume on average per week (circle): 1-2 3-4 5-6 7+

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

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

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

Other Health Care Providers

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

Name of previous chiropractor: _____

City: _____ State: _____

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

Name of medical doctor: _____

City: _____ State: _____

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 of Northville'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 (e.g. thank you notes, congratulations cards, special event notifications, 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 Northville of any changes in my health status.

Name of Patient: _____ Date: _____

Personal Representative: _____ Relationship: _____

Signature: _____ Witness: _____