



— 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: \_\_\_\_\_

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 an auto accident, work injury or personal injury claim involving an attorney?  No  Yes

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

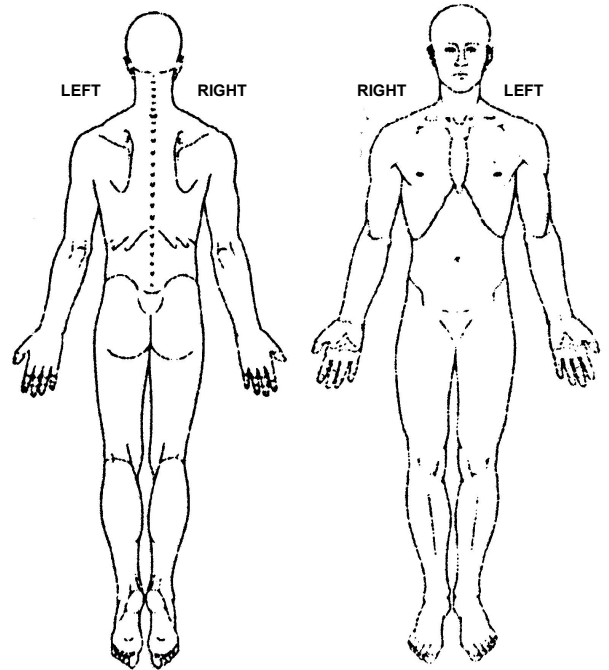
Are your symptoms/pain getting:  Better  Worse  Staying the same

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 = <b>P</b>	Numbness = <b>N</b>	Weakness = <b>W</b>
Soreness = <b>O</b>	Stiffness = <b>X</b>	Swelling = <b>S</b>
Burning = <b>B</b>	Tingling = <b>T</b>	



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:

- |   |  |  |   |  |
|---|--|--|---|--|
| <input type="checkbox"/> Walking            | <input type="checkbox"/> Using telephone         | <input type="checkbox"/> Swimming                          | <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"/> Sitting in recliner     | <input type="checkbox"/> Sewing or crafts                  | <input type="checkbox"/> Mowing lawn        | <input type="checkbox"/> <b>None apply</b> |
| <input type="checkbox"/> Standing           | <input type="checkbox"/> Recreational Activities | <input type="checkbox"/> Doing laundry                     | <input type="checkbox"/> Raking leaves      |  |
| <input type="checkbox"/> Lifting children   | <input type="checkbox"/> Exercising              | <input type="checkbox"/> Making beds                       | <input type="checkbox"/> Gardening          |  |
| <input type="checkbox"/> Reading            | <input type="checkbox"/> Sports                  | <input type="checkbox"/> Vacuuming                         | <input type="checkbox"/> Shoveling snow     |  |
| <input type="checkbox"/> Playing instrument |  |  | <input type="checkbox"/> Combing hair       |  |

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

**NOW HAVE  
IN THE PAST**

- 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
- Loss of Taste
- Difficulty Swallowing
- Difficulty Speaking

**NOW HAVE  
IN THE PAST**

- 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

**NOW HAVE  
IN THE PAST**

- 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): \_\_\_\_\_

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\*Prior illnesses (other than colds and flu): \_\_\_\_\_

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\*Surgeries and hospitalizations: \_\_\_\_\_

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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)

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

Do you have any drug allergies?  No  Yes—describe: \_\_\_\_\_

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

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## 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: \_\_\_\_\_

**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](http://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: \_\_\_\_\_