27850 Gratiot Avenue
Roseville, MI 48066
Phone: (586) 772-5876
Fax: (586) 772-1122

PATIENT INFORMATION CARD

Date ____________________ Social Security # ______________________________

Name ____ Married / Divorced / Separated / Widowed / Single
Last *First* *Middle Initial* *(Circle One)*

Address ____ City _____________________ St _______ Zip ___________

Phone __________________ Work __________________ Cell __________________ E-mail ______________________________

Date of Birth _______________ Age ______ ❑ M ❑ F Ht: ___ft. ___ in. Wt. _______ Referred By ___________________________

Occupation _________________________ Shift _________ Employer _____________________________ How Long __________

Spouse/Guardian ___________________________________ Spouse's Employer ____

Children's names & ages ____

List your **Major Complaints** in order of severity:

1. ____ 3. ____
2. ____ 4. ____

DO YOU HAVE ANY DIFFICULTY WITH ANY OF THE FOLLOWING? (Check all that apply):

❑ Headaches	❑ Fainting or Seizures	❑ Diabetes	❑ Constipation
❑ Shooting Head Pains	❑ Loss of Balance	❑ High Blood Pressure	❑ Diarrhea
❑ Sinus Trouble	❑ Ringing of Ears or Ear Aches	❑ Low Blood Pressure	❑ Painful Menstruation
❑ Loss of Smell / Taste	❑ Hearing Difficulty	❑ Liver Trouble	❑ Irregular Menstruation
❑ Hayfever / Allergies	❑ Eye / Vision Trouble	❑ Anemia	❑ Arthritis
❑ Asthma	❑ Neck Muscle Spasm	❑ Acid Reflux or Ulcers	❑ Tailbone/Sacrum Pain
❑ Cancer	❑ Grating in Neck	❑ Abdominal Pain	❑ Painful Joints
❑ Throat Trouble	❑ Tightness in Shoulder Muscles	❑ Stomach Trouble	❑ Swollen Joints
❑ Infections	❑ Pain in Shoulders & Arms	❑ Indigestion	❑ Hip Pain
❑ Thyroid Trouble	❑ Pins & Needles in Arms & Hands	❑ Nerves, Nervousness	❑ Slipped Disc
❑ Sleeping Trouble	❑ Cold Hands	❑ Inner Tension	❑ Pinched Nerve in Back
❑ Facial Pain or Palsy	❑ Chest Pains or Rib Pains	❑ Irritability–Moodiness	❑ Pins & Needles in Legs
❑ Loss of Memory	❑ Shortness of Breath	❑ Prostate Trouble	❑ Swollen Ankles
❑ Chronic Fatigue	❑ Carpal Tunnel Syndrome	❑ Bladder Problems	❑ Cold Feet
❑ Depression / Anxiety	❑ Fibromyalgia	❑ Gall Bladder Problems	❑ Numbness in Legs
❑ Stress	❑ Heart Palpitation or Heart Trouble	❑ Kidney Trouble	❑ Knee Pain
❑ Dizziness / Vertigo	❑ Upper Back Pain	❑ Buttocks Pain	❑ Groin Pain
❑ Neck Pain	❑ Mid Back or Shoulder Blade Pain	❑ Low Back Pain	❑ Pain in Legs and Feet

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List any **Accidents or Injuries** in the past year ____

in the past 1-10 years ____

in the past 10-20 years ____

List all **Surgeries** and when ____

List all **Medications** and what they're for ____

Is Your Condition a Result of Your: ❑ Employment ❑ Auto Accident ❑ Personal Injury ❑ Other ____________________

Previous Chiropractic care? ❑ Yes ❑ No When? _____________ Where? ______________________________________

Name of **Primary/Family doctor** *(phone, address)* ____

Primary Insurance ____ Subscriber's Date of Birth ____________________

Subscriber's Employer ______________________________________ Subscriber's SS# ___________________________

Secondary Insurance ______________________________________ Subscriber's Date of Birth ____________________

Subscriber's Employer ______________________________________ Subscriber's SS# ___________________________

Do you have an HSA / FSA / MSA / HCC... Spending Account? ❑ Y ❑ N

Signature ____ Date ____________________

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chiropractic center

HEALTH QUESTIONNAIRE

Patient Name ____ Date ______________
When did this episode begin? ______________________________________ (days, weeks, months, years)
What happened? ____

Has this condition existed in the past?
☐Yes ☐No ☐Yes, but has been dormant
☐Comes & goes ☐Symptoms ongoing

How frequent do your symptoms occur?
☐Infrequent ☐Occasional
☐Frequent ☐Constant

How are your daily activities affected?
☐Doesn't affect ☐Somewhat affects
☐Seriously affects ☐Prevents activities

Check the quality of your symptoms (all that apply):
☐Dull ☐Sharp ☐Aching
☐Burning ☐Numbing ☐Tingling
☐Spasm ☐Stinging ☐Shooting
☐Stiff ☐Pounding ☐Constricting

Is this condition getting progressively worse?
☐Yes ☐No ☐Constant ☐Comes & goes

What relieves your pain?
☐AM ☐PM ☐Standing ☐Sitting
☐Heat ☐Ice ☐Stretching ☐ Exercise
☐Bed Rest ☐Nothing ☐ Other_______________

What aggravates your pain?
☐AM ☐PM ☐Standing ☐Reaching
☐Sitting ☐Stairs ☐ Sneezing ☐Coughing
☐Lifting ☐Bending ☐Neck Movement
☐Other______________________________

Does your pain/symptoms radiate to your:
☐Head ☐Face ☐Shoulders ☐Arms
☐Hands ☐Fingers ☐Buttocks ☐Hip
☐Rear thigh ☐Front thigh ☐Calf ☐Shin
☐Ankle ☐Foot ☐Toes

On a scale of 0-10 (10= the worst) how bad does it get when it's at its worst? ________

Is this condition interfering with your:
☐Work ☐Sleep ☐Daily Routine
☐Family Life ☐Hobbies ☐Sexual Function
☐Social Life ☐Other__________________

How long has it been since you felt good?
☐Weeks ☐ Months ☐Years ☐Other____

Sleep:
Do you have trouble falling asleep? ☐Yes ☐No
Do you awake in the middle of the night? ☐ Yes ☐No
Do you awake earlier than normal? ☐ Yes ☐No
Do you not feel well-rested? ☐ Yes ☐No

Other Health Care Providers you have tried:
☐Family MD ☐Neurologist ☐Physical Therapist
☐Massage ☐Gynecologist ☐Orthopedic Surgeon
☐Counselor ☐Proctologist ☐Gastroenterologist
☐Psychiatrist ☐Psychologist ☐Ear, nose & throat
☐Hypnotist ☐Acupuncturist ☐Endocrinologist
☐Allergist ☐Heart Specialist ☐Internist
☐Pulmonary Specialist ☐Chiropractor ☐Nutritionist
☐Kidney Specialist ☐Pain Specialist
☐Rheumatologist ☐Other___________________

Check off any Tests you have received:
☐X-Ray ☐MRI ☐CAT Scan
☐EKG ☐Allergy Test ☐Nerve Conduction test
☐EMG Bone Scan ☐Bone Density Test
☐Myelogram ☐Ultrasound ☐Other_________

Check off any Treatments you have tried:
☐OTC drugs ☐Ice Prescription drugs
☐Massage ☐Cortisone shots
☐Electrical stimulation ☐Manipulation
☐Heat Ultrasound ☐ Physical therapy
☐Ointments ☐Surgery ☐Acupuncture
☐Traction ☐Manipulation ☐Other__________

Work History:
Do your present complaints affect the number of hours you work per day? ☐Yes ☐No

Are you working beyond your physical limitations because you ***have*** to work? ☐Yes ☐ No
Job involves: ☐Lifting ☐Bending ☐Stooping
☐Twisting ☐Turning ☐Carrying ☐Walking
☐Sitting ☐Other_______________
Has this caused you to miss work? ☐Yes ☐ No
If so, how much?_______Last day worked?_________
If **RETIRED**, what occupation did you retire from?
____
If **DISABLED**, what is your disability and how long have you been disabled?
____
____
____
What was your last employed function?
____
Highest level of formal education completed?
____

Patient Name ____

Check any MEDICATIONS you are taking, including Over-The-Counter (OTC) & Prescription (Rx):

(Check all that apply)	OTC	Rx	(Check all that apply)	OTC	Rx	(Check all that apply)	OTC	Rx
Headaches	☐	☐	Headaches	☐	☐	Headaches	☐	☐
Pain	☐	☐	Pain	☐	☐	Pain	☐	☐
Muscle Relaxants	☐	☐	Muscle Relaxants	☐	☐	Muscle Relaxants	☐	☐
Arthritis	☐	☐	Arthritis	☐	☐	Arthritis	☐	☐
Steroids	☐	☐	Steroids	☐	☐	Steroids	☐	☐
Sinus/Allergies	☐	☐	Sinus/Allergies	☐	☐	Sinus/Allergies	☐	☐
Asthma/Bronchitis	☐	☐	Asthma/Bronchitis	☐	☐	Asthma/Bronchitis	☐	☐
Sleeping	☐	☐	Sleeping	☐	☐	Sleeping	☐	☐

Do you have difficulties with any of the following ACTIVITES? (Check all that apply)

☐Bathing	☐Drying Hair	☐Brushing Teeth	☐Put on Shoes	☐Preparing Meals	☐Put Trash Out
☐Showering	☐Combing Hair	☐Making Bed	☐Tying Shoes	☐Eating	☐Laundry
☐Washing Hair	☐Washing Face	☐Putting on Shirt	☐Put on Pants	☐Washing dishes	☐Going to toilet
☐Standing	☐Walking	☐Kneeling	☐Bending Back	☐Twisting Left	☐Leaning Left
☐Sitting	☐Stooping	☐Reaching	☐Bending Left	☐Twisting Right	☐Leaning Right
☐Reclining	☐Squatting	☐Bending Forward	☐Bending Right	☐Leaning Forward	☐Leaning Back
☐Prolong Standing	☐Prolong Sitting	☐Prolonged walk	☐Prolong Kneel	☐Climbing inclines	☐Driving Car
☐Carry Objects	☐Lift from Floor	☐Pushing	☐Exercise upper	☐Climbing stairs	☐Using keyboard
☐Carry Briefcase	☐Lift from Table	☐Pulling	☐Exercise Lower	☐Exercise Arms	☐Exercise Legs
☐Bowling	☐Jogging	☐Swimming	☐Ice Skating	☐Comp Sports	☐Dating
☐Golfing	☐Dancing	☐Skiing	☐Roller Skating	☐Hobbies	☐Dining Out
☐Concentrating	☐Seeing	☐Hearing	☐Touching	☐Tasting	☐Smelling

REVIEW OF SYSTEMS (check all that apply)

General	**Endocrine**	☐Bleeding between periods	☐Tingling	☐Goiter
☐Chills	☐Weight gain	☐Breast lumps	☐Numbness	☐Gonorrhea
☐Faiting	☐Weight loss	☐Miscarriage	☐Un-coordination	☐Gout
☐Fever	☐Hoarseness	☐Extreme menstrual pain	**Psychiatric**	☐Heart disease
☐Forgetfulness	☐Heat Intolerance	☐Hot flashes	☐Hyperventilation	☐Hepatitis
☐Loss of Weight	☐Cold Intolerance	☐Nipple discharge	☐Insecurity	☐Hernia
☐Nervousness	☐Breast Changes	☐Painful intercourse	☐Trouble sleeping	☐Herpes
☐Sweats	☐Hair Changes	☐Vaginal discharge	☐Irritable	☐High Cholesterol
Genito-Urinary	☐Extreme Thirst	☐Vaginal Infections	☐Undecideness	☐HIV Positive
☐Blood in urine	**Gastrointestinal**	☐Last menstrual period ______	☐Timid	☐Kidney Disease
☐Frequent urination	☐Appetite poor	☐Last pap smear __________	☐Hallucinations	☐Liver disease
☐Lack of bladder control	☐Bloating	☐Last mammogram? ________	☐Loss of memory	☐Measles
☐Painful urination	☐Bowel changes	☐Are you pregnant? ________	☐Alcoholism	☐Migraine Headaches
Respiratory	☐Excessive hunger	☐Number of Children________	☐Drug addiction	☐Mononucleosis
☐Cough	☐Excessive thirst	☐Other__________________	☐Drug Dependency	☐Multiple Sclerosis
☐Congestion	☐Gas	**Integumentary (Skin)**	☐Extreme Worry	☐Mumps
☐Distress	☐Hemorrhoids	☐Bruise easy	☐Sexual Problems	☐Pneumonia
☐Sputum	☐Nausea	☐Hives	☐Suicidal Thoughts	☐Polio
☐Shortness of breath	☐Rectal bleeding	☐Change in moles	**Conditions**	☐Psychiatric Care
Ear/Nose/Throat	☐Stomach pain	☐Sores that won't heal	☐AIDS	☐Rheumatic Fever
☐Earache	☐Vomiting no blood	☐Itching	☐Alcoholism	☐Scarlet Fever
☐Ear Discharge	☐Vomiting with blood	☐Unusual swelling	☐Anorexia	☐Stroke
☐Loss of Hearing	**Cardiovascular**	☐Sores/Ulcers	☐Appendicitis	☐Suicide Attempt
☐Nose bleeds	☐Poor circulation	☐Rash	☐Bleeding Disorders	☐Thyroid Fever
☐Hoarseness	☐Rapid heart beat	☐Scars	☐Breast Lumps	☐Ulcers
☐Difficulty Swallowing	☐Swelling of ankles	**Neurological**	☐Bronchitis	☐Venereal Disease
☐Persistent Cough	☐Varicose veins	☐Seizures	☐Bulimia	☐Other_____________
Men Only	**Eyes**	☐Vertigo	☐Cancer	
☐Breast lumps	☐Crossed eyes	☐Dizziness	☐Cataracts	
☐Erection difficulties	☐Double Vision	☐Hand Trembling	☐Chemical Dependency	
☐Lump in testicles	☐Vision- Flashes	☐Loss of sensations	☐Chicken Pox	
☐Penis discharge	☐Vision- Halos	☐Loss of facial expression	☐Diabetes	
☐Sore on penis	☐Blurred vision	☐Weak grip	☐Emphysema	
☐Prostate Problem	**Women Only**	☐Paralysis	☐Epilepsy	
☐Other_________	☐Abnormal pap smear	☐Difficulty of speech	☐Glaucoma	