McMichael Chiropractic Clinic *CONFIDENTIAL PATIENT INFORMATION*

NAME _____ Date _____

Home Phone #_____ Cell Phone #_____ E-mail _____

Address			Zip code		Social Security #
Age	Birth Date	Marital: M S W D	# Children	Driver's License #	Occupation
Employer		Address			Work phone #
If patient is a dependent fill out the two boxes to the right >>		Insured's Name			Social Security #
Insurance Co.			Referred to our clinic by		
Name of Spouse		Occupation		Employer	
Your nearest relative		Address			Phone #

Please completely fill out questions related to your problem on the form below:

Describe your problem	
How did the problem start?	Date problem started or accident happened
Is your problem due to injury or sickness arising from your employment? Yes No Don't know	
Is your problem getting worse? Yes No Constant Comes & Goes	
Is your problem interfering with your: Work Sleep Daily Routine Other (explain)	
What activities or positions make your problem feel worse?	
What makes your problem feel better?	
How long has it been since you felt really good?	Days lost from work
What do you believe is wrong with you?	

Please complete the following questions related to your current and past medical history:

Have you ever had a similar condition? Yes No (if yes, note when and describe)	
Other doctors seen for this condition & treatment received:	
Date of last physical exam	What operations, surgeries, or injections have you had?
Date of last auto accident	What serious illnesses or injuries have you had?
What medications or drugs are you taking?	
Have you been treated for any other health conditions in the last year? Yes No (if yes, describe)	

>> please continue on the back >>

Have you experienced any of the following? **C=Currently** **P=Past** **N=Never**

C P N Neck pain/stiff	C P N Ulcers	C P N Tuberculosis	C P N Itching
C P N Mid back pain	C P N Nervous/Anxiety	C P N Bruise easily	C P N Varicose veins
C P N Low back pain	C P N Nausea	C P N Venereal disease	C P N Bed-wetting
C P N Foot trouble	C P N Colon trouble	C P N High blood press.	C P N Frequent urination
C P N Headache	C P N Diarrhea	C P N Low blood press.	C P N Kidney infection
C P N Arthritis	C P N Constipation	C P N Heart disease	C P N Kidney stone
C P N Bursitis	C P N Difficult digestion	C P N Rapid heart beat	C P N Menstrual cramps
C P N Numbness	C P N Hemorrhoids	C P N Slow heart beat	C P N Excess menstrual flow
C P N Poor posture	C P N Enlarged thyroid	C P N Stroke	C P N Hot flashes
C P N Scoliosis	C P N Eye pain	C P N Poor circulation	C P N Irregular cycle
C P N Sciatica	C P N Failing vision	C P N Chest pain	C P N Lumps in breast
C P N Swollen joints	C P N Ear noises	C P N Difficult breathing	C P N Infertility
C P N Allergy	C P N Deafness	C P N Pleurisy	C P N Diabetes
C P N Hay fever	C P N Nosebleeds	C P N Coughing fluid	C P N Polio
C P N Colds	C P N Sinus infection	C P N Swollen ankles	C P N Alcoholism
C P N Fatigue	C P N Dizziness	C P N Asthma	C P N Depression
C P N Loss of sleep	C P N Anemia	C P N Liver disease	C P N Cancer

Circle the level of each of your habits: **H=Heavy** **M=Moderate** **L=Light** **N=None**

Coffee H M L N	Alcohol H M L N	Tobacco H M L N	Drugs H M L N
Sleep H M L N	Exercise H M L N	Appetite H M L N	Water H M L N

Do you take vitamins or minerals? Yes No (if yes, list types)

Think you may need vitamins or minerals? Yes No

Do you wear?

Heel Lifts Yes No Inner Soles Yes No

Sole Lifts Yes No Arch Supports Yes No

Have any family members had a problem similar to yours?

Circle any of the following conditions a family member has had:

High blood pressure	Stroke	Diabetes	Heart problems	Cancer
Low blood pressure	Scoliosis	Allergy	Lung problems	Arthritis
			Vascular problems	Migraines

Any other comments or remarks:

Name of primary care physician Address

Would you like us to update your medical doctor on your treatment? Yes No

Please complete the following insurance information:

Name of person responsible for payment

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that McMichael Chiropractic Clinic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that an amount authorized to be paid directly to the McMichael Chiropractic Clinic 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 Date

Guardian or Spouse's Signature Authorizing Care Date

Physician Notes: _____

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Doctor _____