

**HealthZone Chiropractic Center**

1001 Gornick Ave  
Gaylord MI 49735  
(989) 732-1533

Title: Mr. Mrs. Ms. Last: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_ (Cell) \_\_\_\_\_

Marital Status: S M D W Number of Children: \_\_\_\_\_

Whom may we thank for referring to you? \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ Insurance

Company: \_\_\_\_\_

Is this visit due to an automobile or work accident? \_\_\_\_\_ **PLEASE**

**FILL IN THE APPROPRIATE SPACES (All information you give is confidential):**

MAJOR COMPLAINT: \_\_\_\_\_

\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Date Began: \_\_\_\_\_

Have you lost work days: Yes ( ) No ( ) How many? \_\_\_\_\_

Have you had this similar condition before? Yes ( ) No ( ) When? \_\_\_\_\_

When did you last see a chiropractor? \_\_\_\_\_ Dr: \_\_\_\_\_

Why did you see this chiropractor? \_\_\_\_\_ Were you helped? \_\_\_\_\_

What spinal maintenance programs were you given to follow to maximize the future of your spine?

\_\_\_\_\_

Did you follow it? \_\_\_\_\_ If not, why? \_\_\_\_\_

Why are you changing chiropractors? \_\_\_\_\_

I understand and agree that health insurance policies are an agreement between an insurance carrier and myself. I understand that this office will supply any necessary reports or information to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered to me will be immediately due and payable. I UNDERSTAND THAT PAYMENT FOR SERVICE IS DUE AT THE TIME OF SERVICE. I hereby authorize the Doctor(s) of chiropractic at HealthZone Chiropractic to perform an examination and administer chiropractic care as deemed necessary.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PAST (O) OR PRESENT (X) CONDITIONS:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Fractured Bones               | <input type="checkbox"/> Learning Disability               | <input type="checkbox"/> Wheezing                          |
| <input type="checkbox"/> Auto Accident                 | <input type="checkbox"/> Mistake sidedness                 | <input type="checkbox"/> Heart Problems                    |
| <input type="checkbox"/> 0 - 1 years ago               | <input type="checkbox"/> Stutter                           | <input type="checkbox"/> Stroke                            |
| <input type="checkbox"/> 1 - 5 years ago               | <input type="checkbox"/> Dyslexia                          | <input type="checkbox"/> High or low blood pressure        |
| <input type="checkbox"/> More than 5 years ago         | <input type="checkbox"/> Mood Changes                      | <input type="checkbox"/> Varicose Veins                    |
| <input type="checkbox"/> Other Accidents/Falls         | <input type="checkbox"/> Lose Temper easily                | <input type="checkbox"/> Liver Trouble                     |
| <input type="checkbox"/> Knocked Unconscious           | <input type="checkbox"/> Headache                          | <input type="checkbox"/> Gall Bladder trouble              |
| <input type="checkbox"/> Back Curvature                | <input type="checkbox"/> Neck pain or stiff R, L           | <input type="checkbox"/> Digestive trouble                 |
| <input type="checkbox"/> Mental or Emotional Disorders | <input type="checkbox"/> Numbness, tingling, or pain       | <input type="checkbox"/> Excessive Gas                     |
| <input type="checkbox"/> Arthritis                     | arms, hands, fingers R L                                   | <input type="checkbox"/> Belching/ bloating after          |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Jaw pain or click (TMJ) R L       | meals  |
| <input type="checkbox"/> Swollen or painful joints     | <input type="checkbox"/> Head seems to heavy               | <input type="checkbox"/> Heartburn                         |
| <input type="checkbox"/> Convulsions or epilepsy       | <input type="checkbox"/> Head & Shoulders feel tired       | <input type="checkbox"/> Ulcers                            |
| <input type="checkbox"/> Skin Problems                 | <input type="checkbox"/> Difficulty in excessive (standing | <input type="checkbox"/> Diarrhea/ constipation            |
| <input type="checkbox"/> Itching                       | walking, sitting, riding, bending,                         | <input type="checkbox"/> Colon Trouble                     |
| <input type="checkbox"/> Bruise Easily                 | lifting, twisting, household duties)                       | <input type="checkbox"/> Hemorrhoids                       |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Shoulder pain R L                 | <input type="checkbox"/> Prostate Problems                 |
| <input type="checkbox"/> Frequent colds/flu            | <input type="checkbox"/> Dizziness                         | <input type="checkbox"/> Impotence                         |
| <input type="checkbox"/> Nervous                       | <input type="checkbox"/> Ringing in ears R L               | <input type="checkbox"/> Kidney Trouble                    |
| <input type="checkbox"/> Tension                       | <input type="checkbox"/> Hearing loss R L                  | <input type="checkbox"/> Kidney Stones                     |
| <input type="checkbox"/> Depressed                     | <input type="checkbox"/> Fainting                          | <input type="checkbox"/> Frequent urination                |
| <input type="checkbox"/> Irritable                     | <input type="checkbox"/> Loss of balance                   | <input type="checkbox"/> Discharge                         |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Blurred or double vision RL       | <input type="checkbox"/> Menstrual problems/ PMS           |
| <input type="checkbox"/> Excess Sweating               | <input type="checkbox"/> Upper back pain or stiffness RL   | <input type="checkbox"/> Menopausal problems               |
| <input type="checkbox"/> Tremors                       | <input type="checkbox"/> Mid back pain or stiffness RL     | <input type="checkbox"/> Breast lumps, soreness, discharge |
| <input type="checkbox"/> Light bothers eyes            | <input type="checkbox"/> Lower back pain or stiffness RL   | <input type="checkbox"/> Pregnant (currently)              |
| <input type="checkbox"/> Allergy                       | <input type="checkbox"/> Numbness, tingling or pain in     | <input type="checkbox"/> Bed-wetting                       |
| <input type="checkbox"/> Sinus Problems                | buttocks, thighs, legs, feet, toes RL                      | <input type="checkbox"/> Ear Infections                    |
| <input type="checkbox"/> Light headed upon rising      | <input type="checkbox"/> Pain with cough, sneeze, or       | <input type="checkbox"/> Hepatitis                         |
| <input type="checkbox"/> Under Stress                  | strain at stools   | <input type="checkbox"/> Venereal disease                  |
| <input type="checkbox"/> Craves sweets or salt         | <input type="checkbox"/> Hip pain R L                      | <input type="checkbox"/> AIDS/HIV                          |
| <input type="checkbox"/> Eating Disorders              | <input type="checkbox"/> Foot trouble R L                  | _____  |
| <input type="checkbox"/> Trouble Sleeping              | <input type="checkbox"/> Chest Pain                        | _____  |
| <input type="checkbox"/> Trouble Concentrating         | <input type="checkbox"/> Asthma                            | _____  |

WHAT IS YOUR HEALTH PHILOSOPHY? (What should you do to be healthy?) \_\_\_\_\_

**HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?**

- Temporary Relief (Help the symptoms but do not fix the cause of the problem)
- Maximum Correction (Correct the cause of the problem for maximum stability in the future)

WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US?

What surgeries have you had: \_\_\_\_\_

List drugs you now take (prescription and non-prescription): \_\_\_\_\_

Name other doctors you have seen for this condition: what was done, and for how long? \_\_\_\_\_

Are you currently wearing: Heel lifts ( ) Arch supports ( )

PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE. \_\_\_\_\_

Signature

Print

Date

