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

Title: Mr. Mrs. Ms. Last:_____ First: _____ MI:_____
Address:_____ City:_____ State:_____ Zip:_____
Birthdayte: _____ 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 is 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:

___ Fractured Bones
___ Auto Accident
___ 0 - 1 years ago
___ 1 - 5 years ago
___ More than 5 years ago
___ Other Accidents/Falls
___ Knocked Unconscious
___ Back Curvature
___ Mental or Emotional Disorders
___ Arthritis
___ Diabetes
___ Swollen or painful joints
___ Convulsions or epilepsy
___ Skin Problems
___ Itching
___ Bruise Easily
___ Cancer
___ Frequent colds/flu
___ Nervous
___ Tension
___ Depressed
___ Irritable
___ Anemia
___ Excess Sweating
___ Tremors
___ Light bothers eyes
___ Allergy
___ Sinus Problems
___ Light headed upon rising
___ Under Stress
___ Craves sweets or salt
___ Eating Disorders
___ Trouble Sleeping
___ Trouble Concentrating

___ Learning Disablity
___ Mistake sidedness
___ Stutter
___ Dyslexia
___ Mood Changes
___ Lose Temper easily
___ Headache
___ Neck pain or stiff R, L
___ Numbness, tingling, or pain arms, hands, fingers R L
___ Jaw pain or click (TMJ) R L
___ Head seems to heavy
___ Head & Shoulders feel tired
___ Difficulty in excessive (standing walking, sitting, riding, bending, lifting, twisting, household duties)
___ Shoulder pain R L
___ Dizziness
___ Ringing in ears R L
___ Hearing loss R L
___ Fainting
___ Loss of balance
___ Blurred or double vision RL
___ Upper back pain or stiffness RL
___ Mid back pain or stiffness RL
___ Lower back pain or stiffness RL
___ Numbness, tingling or pain in buttocks, thighs, legs, feet, toes RL
___ Pain with cough, sneeze, or strain at stools
___ Hip pain R L
___ Foot trouble R L
___ Chest Pain
___ Asthma

___ Wheezing
___ Heart Problems
___ Stroke
___ High or low blood pressure
___ Varicose Veins
___ Liver Trouble
___ Gall Bladder trouble
___ Digestive trouble
___ Excessive Gas
___ Belching/ bloating after meals
___ Heartburn
___ Ulcers
___ Diarrhea/ constipation
___ Colon Trouble
___ Hemorrhoids
___ Prostate Problems
___ Impotence
___ Kidney Trouble
___ Kidney Stones
___ Frequent urination
___ Discharge
___ Menstrual problems/ PMS
___ Menopausal problems
___ Breast lumps, soreness, discharge
___ Pregnant (currently)
___ Bed-wetting
___ Ear Infections
___ Hepatitis
___ Venereal disease
___ AIDS/HIV
_____
_____
_____

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