Rose City Chiropractic Clinic, P.C.

3292 N. M-33
Rose City, MI 48654
989-685-2631

PERSONAL HISTORY

Name ____ Address ____

City ________________________ State__________ Zip _________________ Social Sec. #______________________________

DOB________________ Home Phone ______________________________ Cell________________________________

Email____ **Please provide your email address to view your personal health information online.**

Business/Employer ____ Type of Work ____________________________

Age: _____ Sex: ☐ Male ☐ Female Referred to This Office By: ____

Who is your primary care practitioner/physician? _____________________ How did you hear about us? _______________

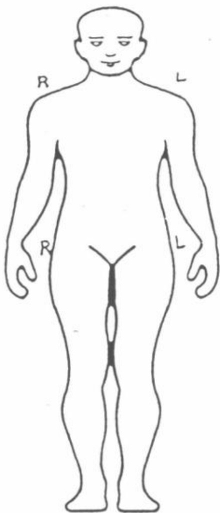
Married: ☐ Yes ☐ No Do You Have Insurance? ☐ Yes ☐ No Name of Insurance Company: ____________________

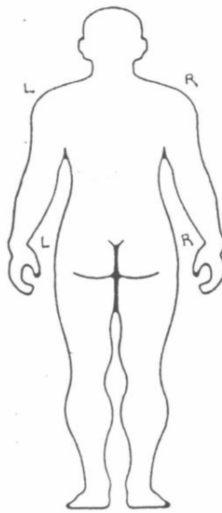
Name of Emergency Contact ____ Phone ____________________________

Briefly describe your condition(s) for which you are here today____

____

Please mark an X on all areas of pain and circle all areas of numbness, tingling, or weakness. Draw a line from a number on the pain scale to the corresponding area of the body you are experiencing pain. 0 being no pain and 10 excruciating pain.





0
1
2
3
4
5
6
7
8
9
10

Place an X over the corresponding area of the body you are experiencing pain. Write in a number from 0-10 with 0 being no pain and 10 excruciating pain near the X you just marked.

Please circle the types of pain that most describe your primary area of complaint:

Sharp **Achy** **Burning** **Tightness** **Stiffness**

Throbbing **Tingling** **Numbness**

Frequency: ☐ Constant75%-100% ☐ Frequent 50%-75% ☐ Occasional 25%-50% ☐ Intermittent <25%

These activities currently aggravate my condition: ☐ Sitting ☐ Standing ☐ Walking ☐ Sleeping
☐ Arising from a chair ☐ Housework ☐ Using computer ☐Bending at Waist ☐ Neck Movements
☐ Arm Movements ☐ Other ____

Relief from this condition has been achieved by using: ☐ Pain meds ☐ Resting ☐ Sitting ☐ Walking
☐ Cold ☐ Heat ☐ BioFreeze ☐ Nothing has helped relieve the pain

What Do You Believe Caused this Condition?
☐ Working in the Yard/Gardening ☐ Unknown Factors ☐ A Fall ☐ A Trauma ☐ Auto Accident
☐ Work Injury ☐ Cutting Wood ☐ Slipping on Ice ☐ Other (please describe):___________________

____

When did your condition start? ☐ Today ☐ Yesterday ☐ Recently ☐ 1-2 Weeks ago
☐ 3-4 Weeks ago ☐ Over 1 Month ago ☐ More Than a Year ago or ☐ Date_______________

Have you had a similar condition before? ☐Yes ☐No If so, how many times? ☐ One ☐ Two ☐ Several ☐ Multiple

Is your condition? ☐ Worsening ☐ Staying the Same ☐ Gradually Improving

☐ Have you had x-rays taken of the spine in the past two years? ☐ Yes ☐ No If Yes, When & Where __________
____

If Yes, what areas of the spine were x-rayed? ____

Do you have any of the following Heart Troubles? ☐ No Known Heart Conditions ☐ Chest Pain ☐ Palpitations
☐ Fainting ☐ Shortness of Breath ☐ Ankle Swelling

Do you have muscle or joint problems? ☐ Joint Pain ☐ Joint Weakness ☐ Muscle Weakness

Please check all past and/or present medical conditions:
☐ Diabetes ☐ Lung Disease ☐ Stomach Problems ☐ Ulcer Disease ☐ Kidney Disease ☐ Mitral Valve Prolapse
☐ High Cholesterol ☐ Heart Problems ☐ Asthma ☐ Bleeding Easily ☐ Arthritis ☐ Cancer
☐ HIV ☐ MRSA ☐ Liver Disease ☐ Sinus Issues ☐ Headaches ☐ Ringing in Ears

List all other medical conditions not listed____

Have you had any neck, back or hip surgery? ☐ Yes ☐ No If yes please explain:_____________________________
Have you ever fractured bones in the spine? ☐ Yes ☐ No If yes please explain: _____________________________
Have you had knee, ankle or shoulder surgery? ☐ Yes ☐ No If yes please explain:_____________________________

List any past surgeries____

Have you ever had a stroke or Transient Ischemic Attack (TIA)? ☐ Yes ☐ No If yes please explain:_________________

Have you ever had an abdominal aneurysm? ☐ Yes ☐ No If yes please explain: ________________________________
Do you: ☐ Have a pacemaker? ☐ Have a heart stent? ☐ Previous bypass surgery?
Have you been told you have a blockage of the arteries in the neck? ☐ Yes ☐ No If yes please explain:_______________

Are you allergic to any medications? ☐ Yes ☐ No
If yes, please list medications you are allergic to and the severity of your reaction:
_______________________________________ ☐ mild ☐ moderate ☐ severe
_______________________________________ ☐ mild ☐ moderate ☐ severe
Please list any medications you are currently taking.

Blood Pressure (if known) _________________ Height _________ Weight __________

Smoking Status: ☐ every day smoker ☐ occasional smoker ☐ former smoker ☐ never smoked

Have You Had Chiropractic Care Before? ☐ Yes ☐ No If yes, Dr's Name & Date of visit: ________________________

Are you currently pregnant? ☐ Yes ☐ No

List any additional pertinent information____

____

AUTHORIZATION AND ASSIGNMENT

In consideration of you undertaking to treat me, I agree to the following:

You are authorized to release any information concerning my physical condition to any insurance company, attorney or adjuster, including the health care financing administration and Medigap as well as my primary care provider in order to process any claim for reimbursement of charges.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company of the health care financing administration or Medigap obligated for the charges of your services.

Analysis:
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of vertebral subluxation. When subluxation complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

Diagnosis:
Although doctors of chiropractic are experts in chiropractic diagnosis, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

Informed Consent for the Chiropractic Care:
A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment of other clinical procedures is usually beneficial and seldom causes any problem. In rare cases underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care if he/she is aware that such care may be contra-indicated. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I have read and understand the foregoing.

______________________________ Date

____ Signature

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

The Privacy Act requires your consent to release health or billing information to family members. Only the names listed below will be given information regarding your medical condition or billing information.

I hereby authorize Rose City Chiropractic Clinic, PC, its staff and providers to disclose my protected health information to the following representatives:

Name:_______________________________________ Relationship:____________________________________

Name:_______________________________________ Relationship:____________________________________

Name:_______________________________________ Relationship:____________________________________