GET WELL
CHIROPRACTIC

Case Number

Today's Date

CA DC

Tell Us About You

Title:_____ First:_____ MI:___ Last:_____

Nickname:_____ Birth date:_____ Age:_____ Sex: ❒ Male ❒ Female

Current address:_____

City:_____ State:_____ Zip:_____ SS #:____-____-_____

Primary Tel:_____-_____-_____ H / W / C Alt. Tel:_____-_____-_____ H / W / C

Email:_____

Whom may we thank for referring you?_____

Marital status: ❒ Single ❒ Divorced ❒ Widowed ❒ Married to:_____

# of children:_____ Ages of children:_____

Employment status: ❒ Full-time ❒ Part-time ❒ Not employed ❒ Self ❒ Retired ❒ Military

Occupation:_____ Employer:_____

Student: ❒ No ❒ Full-time ❒ Part-time School name:_____

Alternate address:_____

City:_____ State:_____ Zip:_____ Parents/Other:_____

Emergency Contact:_____ Phone:_____-_____-_____

Emergency contact is your: ❒ Spouse/partner ❒ Parent ❒ Other:_____

Tell Us Why You're Here

What is the primary reason for your visit?_____

_____

Is this due to a: ❒ Automobile accident ❒ Work-related injury ❒ Personal injury case ❒ None

When did your pain/symptoms begin (include date if possible)?_____

In your own words and in your own opinion, what do you think the real problem is?_____

_____

The overall severity of your complaints/concerns is:

❒ Mild ❒ Mild to moderate ❒ Moderate ❒ Moderately severe ❒ Severe

The overall frequency is: ❒ Occasional ❒ Intermittent ❒ Frequent ❒ Constant

If your symptoms change, when are they worse: ❒ Morning ❒ Afternoon ❒ Evening ❒ Night ❒ NA

On a Scale of 0-10 (10 Being Unbearable; 0 being No Pain or Discomfort), Please Rate The Following...

The HIGHEST your pain gets WITHOUT medication: _____

The LOWEST your pain gets WITHOUT medication: _____

The HIGHEST your pain gets WITH medication: _____

The LOWEST your pain gets WITH medication: _____

Are your symptoms/pain getting: ❒ Better ❒ Worse ❒ Staying the same

Is there anything you can do that makes it feel better?_____

Have you had the same or similar problems in the past? ❒ No ❒ Yes—When:_____

Have you had recent treatment for this condition? ❒ No ❒ Yes—please list dates and doctors:_____

_____

_____

What kinds of treatments have you received?

❒ Epidural: How Many: _____ When (approx): _____

❒ Physical Therapy: How Long: _____ When (approx): _____

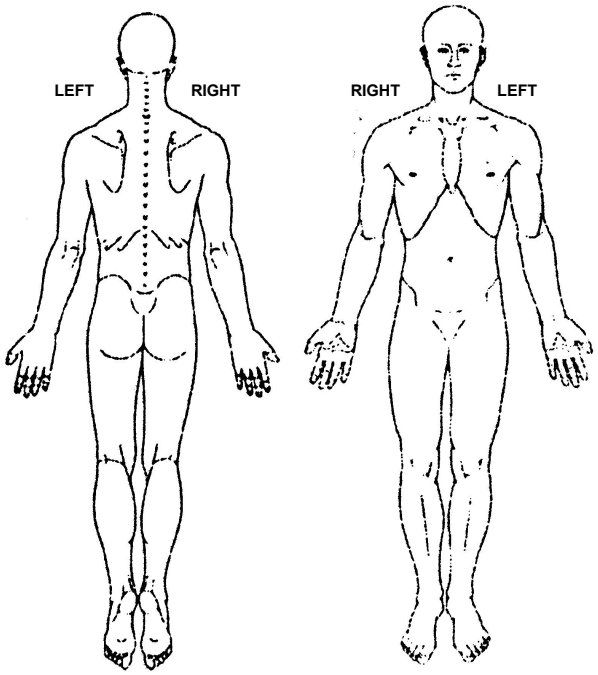
❒ Medication: _____ When (approx): _____

❒ Surgery: Type: _____ When (approx): _____

❒ Other: _____

Use the following key to mark your complaints on the diagram at the right:

Pain = **P**	Numbness = **N**	Weakness = **W**
Soreness = **O**	Stiffness = **X**	Swelling = **S**
Burning = **B**	Tingling = **T**	



If your complaints include pain, how would you describe it? (please check all that apply):

❒ Aching ❒ Burning ❒ Dull ❒ Sharp ❒ Shooting

❒ Stabbing ❒ Throbbing ❒ Other:_____

Since your symptoms began, have you noticed any function changes?: ❒ Bowel ❒ Bladder ❒ Sexual ❒ No Changes

Do work activities aggravate your present complaints?

❒ Yes ❒ No ❒ NA

How often does your job involve lifting? ❒ Never ❒ Occasionally ❒ Frequently ❒ Constantly

Other job requirements (please check all that apply): ❒ Bending ❒ Carrying ❒ Stooping

❒ Twisting ❒ Turning ❒ Walking ❒ Other:_____

What is your primary work position? ❒ Seated ❒ Standing ❒ Other:_____

Your Activities of Daily Living

Please indicate which activities of daily living are compromised by your current state of health:

- ❒ Walking
- ❒ Sitting
- ❒ Climbing stairs
- ❒ Chewing
- ❒ Kneeling
- ❒ Sleeping
- ❒ Standing
- ❒ Lifting children
- ❒ Reading
- ❒ Playing instrument
- ❒ Using telephone
- ❒ Running
- ❒ Bending
- ❒ Lying in bed
- ❒ Using computer
- ❒ Exercising
- ❒ Sitting in recliner
- ❒ Sports
- ❒ Swimming
- ❒ Recreational activities
- ❒ Getting into/out of an automobile
- ❒ Driving a car
- ❒ Riding in a car
- ❒ Other travel
- ❒ Sewing or crafts
- ❒ Doing laundry
- ❒ Making beds
- ❒ Vacuuming
- ❒ Washing dishes
- ❒ Ironing
- ❒ Carrying groceries
- ❒ Caring for pets
- ❒ Cooking
- ❒ Mowing lawn
- ❒ Raking leaves
- ❒ Gardening
- ❒ Shoveling snow
- ❒ Combing hair
- ❒ Shaving
- ❒ In/out of bathtub
- ❒ Brushing teeth
- ❒ _____
- ❒ _____
- ❒ **None apply**

Please mark whether you NOW HAVE (❍) or had IN THE PAST (❒) any of the following conditions/illnesses:

NOW HAVE	IN THE PAST		NOW HAVE	IN THE PAST		NOW HAVE	IN THE PAST	
❍	❒	Allergies	❍	❒	Sinus Trouble	❍	❒	Erectile Dysfunction
❍	❒	Hay Fever	❍	❒	Asthma	❍	❒	Fertility Problems
❍	❒	Fatigue or Weakness	❍	❒	Wheezing	❍	❒	Excessive Thirst
❍	❒	Night Sweats	❍	❒	Chronic Cough	❍	❒	Thyroid Trouble
❍	❒	Unexpected Weight Change	❍	❒	Shortness of Breath	❍	❒	Anxiety or Nervousness
❍	❒	Jaw Pain/TMJ	❍	❒	Chest Pain or Pressure	❍	❒	Mood Swings or Irritability
❍	❒	Sleeping Problems	❍	❒	Heart Trouble	❍	❒	Mental or Emotional Difficulty
❍	❒	Skin Problems	❍	❒	High Blood Pressure	❍	❒	Depression
❍	❒	Loss of Balance	❍	❒	Low Blood Pressure	❍	❒	Arthritis
❍	❒	Dizziness or Lightheadedness	❍	❒	Cold Hands or Feet	❍	❒	Bone Fracture
❍	❒	Vertigo	❍	❒	Abdominal Pain	❍	❒	Dislocated Joints
❍	❒	Fainting	❍	❒	Indigestion / Upset Stomach	❍	❒	Autoimmune Disease
❍	❒	Headaches	❍	❒	Excess Gas	❍	❒	Cancer
❍	❒	Seizures	❍	❒	Heartburn	❍	❒	Diabetes
❍	❒	Loss of Memory	❍	❒	Constipation	❍	❒	Fibromyalgia
❍	❒	Vision Trouble	❍	❒	Diarrhea	❍	❒	Multiple Sclerosis
❍	❒	Hearing Trouble	❍	❒	Nausea or Vomiting	❍	❒	Rheumatic Fever
❍	❒	Ear Infections	❍	❒	Bedwetting	❍	❒	Tuberculosis
❍	❒	Ringing or Buzzing in Ears	❍	❒	Urinary Pain or Frequency	❍	❒	Other:_____
❍	❒	Loss of Smell or Taste	❍	❒	Kidney or Bladder Trouble	❍	❒	**No Conditions/Illnesses**
❍	❒	Difficulty Swallowing	❍	❒	Blood in Urine or Stool			
❍	❒	Difficulty Speaking	❍	❒	Menstrual Problems or Pain			
❍	❒	Weight Issues	❍	❒	Prostate Trouble			

Have you lost any time from chores/tasks at home?_____

_____

Have you lost any time from work?_____

_____

Sickness, Injury and Accident History

***Include DATES, DESCRIPTIONS and specify (R)ight side, (L)eft side or (B)ilaterally as applicable.**

*Accidents (include automobile, work-related, personal injury, slip and fall, or any serious injury):_____

*Prior illnesses (other than colds and flu):_____

*Surgeries and hospitalizations:_____

Have you had any organs or body parts surgically removed?: ❒ No ❒ Yes—list surgery and dates:

Are you currently taking ANY over-the-counter medication: ❒ No ❒ Yes—list name and for what condition.

Are you currently taking ANY prescription medication: ❒ No ❒ Yes—list name and for what condition.

Remember to list ALL drugs including: aspirin, antibiotics, insulin, birth control pills, blood pressure pills, etc.

DRUG	CONDITION	DRUG	CONDITION

Your Lifestyle

Which of the following best describes your stress level: ❒ None ❒ Minimal ❒ Moderate ❒ Extreme

Do you smoke? ❒ No ❒ Yes—How much:_____

Do you exercise? ❒ No ❒ Yes—How often:_____

How many caffeinated drinks do you consume:_____ per day

How many alcoholic drinks do you consume on average per week (circle): 1-2 3-4 5-6 7+

Using a scale from 0 to 10, where 0 equals "awful" and 10 equals "amazing" (please circle):

How would you rate your overall health? 0 1 2 3 4 5 6 7 8 9 10

WOMEN ONLY: To your knowledge are you pregnant? ❒ No ❒ Yes—Due date:_____

If no, are you currently trying to conceive? ❒ No ❒ Yes

Other Health Care Providers

Have you ever been to a doctor of chiropractic before? ❒ No ❒ Yes—How long ago?_____

Name of previous chiropractor:_____

City:_____ State:_____

Do you see a medical doctor or osteopath? ❒ No ❒ Yes—Date of last visit:_____

Name of medical doctor:_____

City:_____ State:_____

Communication is Key to a Positive Relationship

Is there anything else you would like us to know? ❒ No ❒ Yes—_____

_____

_____

_____

To help us ensure clarity of communication, please initial the following:

_____ I acknowledge that I was presented with a copy of the Notice of Privacy Practices on my initial visit which describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Get Well Chiropractic. Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices is on display in the reception room and on Get Well Chiropractic of Northville's website at **www.getwellnorthville.com.** We encourage you to read it in full. You may obtain additional copies of our most current notice by requesting it from our privacy official, Jenni Gowing. If you have any questions regarding this notice of our health information privacy policies, please contact Jenni Gowing, our privacy official.

_____ Get Well Chiropractic may send me birthday cards and holiday greetings.

_____ Get Well Chiropractic may send me personal correspondence (e.g. thank you notes, congratulations cards, special event notifications, etc.)

_____ To the best of my knowledge the questions on this form have been accurately answered.
I understand that providing incorrect or incomplete information can be detrimental to my health.
It is my responsibility to inform Get Well Chiropractic of Northville of any changes in my health status.

Name of Patient: _____ Date:_____

Personal Representative: _____ Relationship:_____

Signature:_____ Witness:_____