Family Chiropractic Healthcare Center, PLLC
4612 Plainfield NE Grand Rapids, MI 49525

File #:_____
Date:_____

Health Questionnaire

Please answer the following questions to the best of your ability. Thank you.

Patient Demographic Information

Name:_____
Last name *First name* *Middle Initial*
Address:_____
City:_____ State:_____ Zip Code:_____
Phone Number: (____)_____ Alternate Number:(____)_____
Gender: □ Male □ Female Age:_____ Date of Birth: ___/_____/____
Social Security Number:_____-_____-_____Driver's License #:_____
E-mail Address:_____ Preferred Language:_____
Ethnicity: (Circle) Decline to Specify, Hispanic/Latino, Not Hispanic
Race: (Circle) Decline to Specify, American Indian, Asian, Black, Pacific Islander, White
How were you referred to Family Chiropractic Health Center?:_____
Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated
Spouse/Partner's Name:_____
Spouse/Partner's Phone:_____
Other Nearest Relative or Contact Person:_____ Phone:_____
If you are a minor, please state the name (s) of your parent(s) or legal guardian(s):_____
_____

Other Healthcare Provider's Information

Primary Care Physician:_____ Date of last visit:_____
Have you received chiropractic care in the past? □ Yes □ No
Please give the date of your last visit, the name of the doctor, and the reason for the previous care:
_____

Occupational History

Occupation: □ Working □ Retired □ Unemployed □ Student
Employer/School:_____
Work Activity: □ Sitting □ Standing □ Twisting □ Bending □Light labor □Heavy labor
Have you ever been injured on the job:_____

Medication(s): List ANY/ALL medications you are CURRENTLY taking. BE SPECIFIC

Medication	Dosage	For what condition?	Length of time taken

Allergies: List ALL allergies to medication(s) or other interactions. Specify reaction.

_____

Supplements: List ANY/ALL non-prescription items you are CURRENTLY taking. BE SPECIFIC

Vit., Minerals, Herbs, etc...	Dosage	For what condition?	Length of time taken

Personal & Family Health History

Have you ever been treated for a spine/nerve disorder: □ Yes □ No Explain:_____
Date of Last:
Chiropractic Exam:_____ X-Ray:_____
MRI:_____ Purpose:_____
CT-Scan:_____ Purpose:_____
Stool check for blood:_____Colonoscopy:_____Eye Exam:_____
Do you currently wear or user any of the following:
□ Heel Lifts □ Innersoles □ Arch Supports □ Orthotics □ Braces □ Wraps □ Cane or crutch

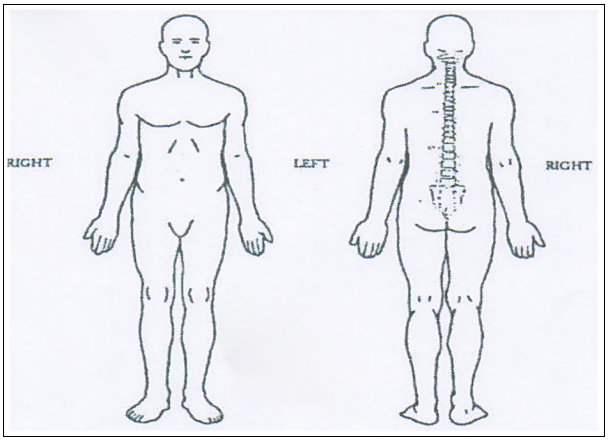
Relation	*Alive/Deceased*	*Age(now/at death)*	*Significant illness / cause of death*
Father			
Mother			
Brother(s)/Sister(s)			

Patient Condition/Major Complaint(s) Information

Reason(s) for your visit today:_____
_____
Is this due to and accident? □ Yes □ No; □ Auto □ Work □ Home □ Other Date :_____
When did your symptom(s) begin? _____
Have you experienced these symptoms before? □ Yes □ No. When?_____
Is this condition getting: □ Better □ Worse □ Staying the same
What makes this condition worse:_____
What makes this condition better:_____
Does it interfere with your:
□ Work □ Sleep □ Self Care □ Daily Routine □ Recreation
Activities or movements that are difficult/painful to perform:

□ Lying on back	□ Getting in/out of car	□ Sleeping	□ Stooping	□ Standing for a long time
□ Lying on side	□ Gripping/reaching	□ Pushing	□ Sitting	□ Sneezing
□ Turning over	□ Climbing	□ Pulling	□ Bending	□ Coughing
□ Lying flat	□ Dressing	□ Washing	□ Walking	□ Sexual Activity

What treatment(s) have you already received for your condition?
□ Chiropractic □ Medications □ Surgery □ Physical Therapy □ None □ Other:
Name of other doctor(s) who has treated you for this condition:_____
Were you Satisfied: □ Yes □ No
Mark your pain on the below scale 0 to 10:
(At rest) No Pain ☺ 1 2 3 4 5 6 7 8 9 10 Extreme Pain/ No Function
(With Activity)No Pain ☺ 1 2 3 4 5 6 7 8 9 10 Extreme Pain/ No Function
Mark on the picture where you continue to have pain, numbness, tingling, etc...



Child & Adult Illness(es); List all past health conditions. Indicate if any are still present.

_____
_____
_____

Surgery(ies): List all Surgical Procedures with the date of the procedure was performed.

_____
_____
_____
_____
_____

Injury (ies): List all injuries. Write the date of the injury immediately afterward and explain.

_____
_____
_____
_____

Social History:

Are you on any special diet? □ Yes □ No; For what reason:_____
Have you gained or lost over 10lbs in the past six months without trying? □ Yes □ No

Tobacco Use: Now? □ Yes □ No (□ Every day, □ Some days, □ Heavy user, □ Light user, □ Ex-smoker)
□ Smoking Start Date:_____ □ Quit Date:_____
Do you currently engage in recreational drug use? □ Yes □ No
Do you have any concerns about your sexual health? □ Yes □ No
Are you or have you ever been a victim of domestic or sexual abuse? □ Yes □ No

Review of Systems

Female: Mark all that apply below

I... □ AM CURRENTLY PREGNANT □ AM CURRENTLY NOT PREGNANT
Menstrual History: Age of first menses:_____ Date of last menses:___/____/_____
I...□ Currently have menses □ Currently DO NOT have menses
My menses... □ Are regular □ Are NOT regular
If you have been pregnant in the past, please fill in the appropriate information below:
_____ # of complicated pregnancies___ # of C-sections_____ # of vaginal deliveries

□ Birth Control □ Cramps □ Hormone therapy □ Urine Retention □ Frequent Urination

Male: □ I have no symptoms/problems in this category.

□ Burning Urination □ Frequent Urination □ Prostate Problems □ Erectile Dysfunction □ Hesitancy/Dribbling

Constitutional: □ I have no symptoms/problems in this category.

□ Chills □ Fatigue □ Night sweats □ Weight Loss □ Daytime Drowsiness □ Fever □ Weight Gain

Eyes/Ears/Nose/Throat: □ I have no symptoms/problems in this category.

□ Poor Vision	□ Nosebleeds	□ Deafness	□ Thyroid problems
□ Blurred Vision	□ Nasal obstruction	□ Earache	□ Frequent colds
□ Cataracts	□ Sinusitis	□ Ear Discharge	□ Ringing in ears
□ Change in vision	□ Nasal Congestion	□ Wear Glasses/Contacts:	
□ Pain in the eyes	□ Sore Throat	Type of correction:_____	

Respiration: □ I have no symptoms/problems in this category.

□ Asthma □ Coughing up blood □ Shortness of Breath □ Wheezing □ Chest Pain □ Chronic cough
□ Rib fracture □ Other:

Allergy: □ I have no symptoms/problems in this category.

□ Anaphalaxis □ Itching □ Sneezing □ Food Intolerance □ Nasal Congestion □ Rash

Psychological: □ I have no symptoms/problems in this category.

□ Anxiety □ Bi-polar Disorder □ Depression □ Behavior Change □ Confusion □ Insomnia □ Memory Loss

Cardiovascular: □ I have no symptoms/problems in this category.

□ Angina (chest pain/discomfort after exertion) □ Palpitations (heart flutter) □ Chest Pain
□ Claudication (leg pain/ache) □ Heart Murmur □ Shortness of breath □ Varicose Veins
□ Hypertension(High Blood Pressure) □ Hypotension (Low Blood Pressure) □ Swelling of legs

Gastrointestinal: □ I have no symptoms/problems in this category.

□ Abdominal Pain □ Difficulty Swallowing □ Nausea □ Vomiting Blood
□ Belching □ Heartburn □ Constipation □ Vomiting
□ Hemorrhoids □ Diarrhea □ Abnormal Stool: Color/Character/Consistency/Amount

Endocrine: □ I have no symptoms/problems in this category.

□ Cold Intolerance □ Excessive Thirst □ Abnormal Frequency of Urination □ Hair Growth
□ Diabetes □ Heat Intolerance □ Voice Changes □ Excessive Hunger □ Hair Loss
□ Goiter □ Thyroid

Skin/allergies: □ I have no symptoms/problems in this category.

□ Changes in Nail Texture □ Hair Loss □ Itching □ Changes in Skin Color □ Rash
□ Hair Growth □ History of Skin Problems □ Skin Lesion/Ulcer

Nervous System: □ I have no symptoms/problems in this category.

□ Dizziness □ Loss of Memory □ Stress
□ Facial Weakness □ Numbness □ Stroke
□ Headache □ Seizures □ Tremor
□ Limb Weakness □ Sleep Disturbances □ Uncontrollable Bowel/Bladder
□ Loss of Consciousness □ Slurred Speech □ Unsteadiness of Gait/Balance

Do you have or have you had any of the following Diseases: □ I have no symptoms/problems in this category.

□ Appendicitis □ Epilepsy □ Pleurisy □ Pneumonia □ Mental disorder
□ Cancer □ Chickenpox □ Whooping cough □ Influenza □ Diabetes
□ Polio □ Eczema □ Arthritis □ Tuberculosis □ HIV
□ Alcoholism □ Heart disease □ Venereal disease □ Anemia □ Rheumatic Fever

As healthcare providers we are concerned about your overall wellness.
On future visits we will discuss issues with you that may impact your overall health.

All of the answers I have given are correct to the best of my knowledge, and I agree to have an examination performed at Family Chiropractic Healthcare Center at this time.

_____ _____
Patient's Signature Date

_____ _____
Signature of Parent or Legal Guardian Relationship

Patient's Initials:_____

Family Chiropractic Healthcare Center, PLLC

4612 Plainfield Ave. NE
Grand Rapids, MI 49525
Phone (616) 363-7713 Fax (616) 363-4958

Personal Financial Responsibility For Care

I understand and agree that if I have health and/or accident insurance policies, that these policies are an arrangement between my insurance company and myself. Any amount paid to this office will be credited to my account upon my receipt. I understand that my insurance policies may cover part, or none of the services rendered. I clearly understand and agree that all services rendered to me are my personal responsibility.

Cancellation Policy

Late cancellations of less than 24hours, and patients who do not show for a scheduled appointment will be charged $45.00. We do not accept walk-in appointments.

How would you like to be reminded of your appointments (PLEASE PICK 1)

□ I would like to be reminded the day before my appointments via text message

Cell phone #:_____ Carrier:_____

□ I would like to be reminded the day before my appointments via email

Email address:_____

□ I do not need to be reminded of my appointment

Authorization To Pay Doctor Directly

I authorize the direct payment to my doctor from my insurance company that is contractually obligated to pay my doctor directly out of any proceeds of any settlement I may receive. A photocopy of this form is acceptable for this authorization.

Authorization To Release Patient Information

I authorize this office to release any information requested by a third party that presents a signed release bearing my signature.
I have read, fully understand and agree to abide by the above policies

Printed Name: _____ Date:_____

Signature: _____ CA:_____

_____ _____
Signature of Parent or Legal Guardian Relationship

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Notice of Your Privacy Rights

I acknowledge that Family Chiropractic Healthcare Center provides the opportunity to review the Notice of Privacy Practices. The Notice of Privacy Practices describes the type 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 operation at Family Chiropractic Healthcare Center. The Notice of Privacy Practices for Family Chiropractic Healthcare Center is also provided on request at the main administration desk. The Notice of Privacy Practices also describes my rights and Family Chiropractic Health Center's duties with respect to my protected health information.

Family Chiropractic Healthcare Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a copy or by asking for one at the time of my next appointment.

Printed Name: _____ Date:_____

Signature: _____ CA:_____

_____ _____
Signature of Parent or Legal Guardian Relationship

I hereby give permission to discuss my case and financial information with the following individuals:

Name	Relationship

Patient's Initials:_____