West Michigan Chiropractic Center, P L.C.

Patient Registration and History

Patient Information (please print or circle information as needed) **Today's Date:_____________**

Cell Phone: ____________________

Name: ____ Home Phone: ____________________
First MI Last

Address:______________________________ City_________________State____Zip _______

Sex: M F Age: _____ B-date: _______Marital Status: Single Married Divorced Widowed

Patient Soc Sec #: _____________________Email: _______________________________________

Occupation: _______________Employer: __________________ Work Phone: _______________

***Spouse's Name (or parents' name for children under 18): _______________________________**

*** Spouse's B-date (or parent's):_______________ Occupation: ___________________________**

***Spouse's Soc Sec # (or parent's)________________________**

Whom may we thank for referring you? ____

In case of emergency whom may we contact? Name: _____________________________________

Relationship: ______________ Home Phone: _______________ Work Phone: ________________

Is condition due to an injury? Yes No If yes type of injury? Auto Work Home Other

To whom have you made a report of your accident? Auto Ins Employer Wk Comp Other

Attorney Information (if applicable) (space can also be used for auto claim # info): _______________________
____

Insurance

Who is responsible for this account? ____________________ Relationship to patient? _____________

Insurance Co: _________________________Subscriber #: __________________ Group#: _________

Is patient covered by additional insurance? Yes No (if yes please fill in additional information)
Subscriber's name: ______________________Relationship to patient: ___________B-date: ___________
Insurance Co: ___________________________ Subscriber #: _________________Group #: _________

Signature on file

I authorize use of this form on **all** my insurance submissions. I authorize release of information to all my **Insurance Companies.** I understand that **I am responsible** for my bill. I authorize Dr. Chris Hawkins to act as **my** agent in helping me obtain payment from my Insurance Companies. I authorize payment direct to West Michigan Chiropractic Center, P.L.C. I permit a copy of this authorization to be used in place of the original.________________

Printed Name: _____________________________ Signature: _________________________________

Place an X in front of all of the following signs and symptoms that you have on a recurring basis. A complete history and understanding of your health status will facilitate care.

GENERAL SYMPTOMS

___ headache
___ fever
___ chills
___ night sweats
___ fainting
___ dizziness
___ convulsions
___ loss of sleep
___ fatigue
___ nervousness
___ loss of weight
___ numbness or pain in arms/legs/hands/feet
___ allergies ________________
___ wheezing

MUSCLE & JOINTS

___ weakness
___ twitching (spasm)
___ stiff neck
___ back ache
___ swollen joints
___ tremors
___ foot trouble
___ painful tail bone
___ pain between shoulders
___ hernia

GASTRO-INTESTINAL

___ poor appetite
___ poor digestion
___ excessive hunger
___ belching or gas
___ nausea
___ vomiting
___ vomiting blood
___ pain over stomach
___ constipation
___ diarrhea
___ colon trouble
___ hemorrhoids
___ liver trouble
___ jaundice
___ gall bladder trouble

CARDIOVASCULAR

___ rapid heart beat
___ slow heart beat
___ high blood pressure
___ low blood pressure
___ pain over heart
___ previous heart trouble
___ swelling of ankles / edema
___ poor circulation
___ varicose veins
___ history of stroke(s)

EYE EAR NOSE THROAT

___ poor vision
___ crossed eyes
___ pain in eyes
___ deafness
___ earache
___ ear noises
___ear discharges
___ nasal obstruction
___ nose bleeds
___ sore throat
___ hoarseness
___ hay fever
___ asthma
___ frequent colds
___ enlarged thyroid
___ tonsillitis
___ sinus trouble

SKIN

___ acne
___ itching
___ bruising easily
___ dryness
___ boils
___ sensitive skin
___ hives
___ eczema

RESPIRATORY

___ chronic cough
___ spitting blood
___ spitting phlegm
___ chest pain
___ difficulty breathing

GENITO-URINARY

___ frequent urination
___ painful urination
___ blood in urine
___ kidney infection
___ bed wetting
___ inability to control urine
___ prostate trouble(men)

FOR WOMEN ONLY

___ painful periods
___ excessive flow
___ irregular cycles
___ hot flashes
___ cramps / back ache
___ miscarriage
___ vaginal discharge
___ pregnant at this time
if so due date: _________

HAVE YOU HAD OR HAVE ANY OF THE FOLLOWING? PLACE AN **X** IF YES, LEAVE BLANK FOR NO.

___ appendicitis
___ diabetes
___ chicken pox
___ multiple sclerosis
___ vaccinations
___ gall bladder
___ rectal surgery
___ anemia
___ cancer __________________
___ mumps
___ epilepsy
___ tonsillectomy
___ appendectomy
___ thyroid
___ heart disease
___ HIV/aids
___ measles
___ rheumatic fever
___ tubes in ears
___ female surgery ___________________
___ back operations __________________
___ arthritis
___ alcoholism
___ polio
___ tuberculosis
___ sinus surgery
___ hernia
___ stomach/ulcer

EXERCISE

___ none
___ moderate
___ daily
___ heavy

WORK ACTIVITY

___ sitting hrs/day _____
___ standing hrs/day _____
___ light labor
___ heavy labor

HABITS

___ smoking packs/day ________
___ alcohol drinks/week _______
___ caffeine cups/day __________
___ high stress reason ____________

FAMILY HISTORY

	DIAB	HEART	CANCER	BACK
mother	____	_____	_______	_____
father	____	_____	_______	_____
siblings	____	_____	_______	_____

LIST ANY ACCIDENTS OR FALLS: Vehicle: ____

Sports: ____ School: ____________________________________

BROKEN BONES OR DISLOCATIONS (FRACTURES): ____

OSTEOPOROSIS ? YES NO Comments____

EVER ON CRUTCHES? YES NO IF YES, WHY? ____

HAVE YOU EVER HAD ANY SPINAL TAPS OR INJECTIONS? YES NO IF YES, WHY? ______________

WERE YOU EVER KNOCKED UNCONSCIOUS? YES NO IF YES, WHY? ___________________________

HAVE YOU EVER HAD A LAPSE OF MEMORY? YES NO IF YES, WHY? ___________________________

HAVE YOU EVER HAD X-RAYS TAKEN? YES NO

HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE? YES NO IF YES, WHO? ____________________

HOW LONG AGO? ______________ WHY DID YOU DISCONTINUE CARE? _____________________________

ARE YOU CURRENTLY TAKING ANY MEDICATIONS, VITAMINS, HERBS, MINERALS? YES NO

IF YES, PLEASE LIST THEM:____

____

____

THANK YOU FOR YOUR COOPERATION IN FILLING OUT THIS FORM TO ENABLE US TO BETTER CARE FOR YOUR HEALTH.

West Michigan Chiropractic Center, P.L.C.

Consultation History

Patient Name: ____ Today's Date: ____________________

If applicable please circle one: Auto Accident Work related injury Other (please specify) __________

Major Complaints:

A) ____ D) ____
B) ____ E) ____
C) ____ F) ____

What have you heard about Chiropractic? ____

Which of your major complaints bother you the most? (circle one) A B C D E F

How long have you had the complaint(s)? ____

Prior to the problem beginning, did you ever have an earlier problem that was the same or similar? _________
____

Did it appear (circle one) Slowly Immediately

Does anyone else in your family have this problem or a similar one? _____________________________________
____

How often does it bother you now? ____

When it is at its worst, how does it feel? ____

When it is at its worst, how does it interfere with your normal daily activities? ____________________________
____

Does this problem reduce your productivity or effectiveness regarding your work? _______________________

What have you done to aggravate the problem? ____
____

How much older than you are, does your current problem make you feel? ________________________________

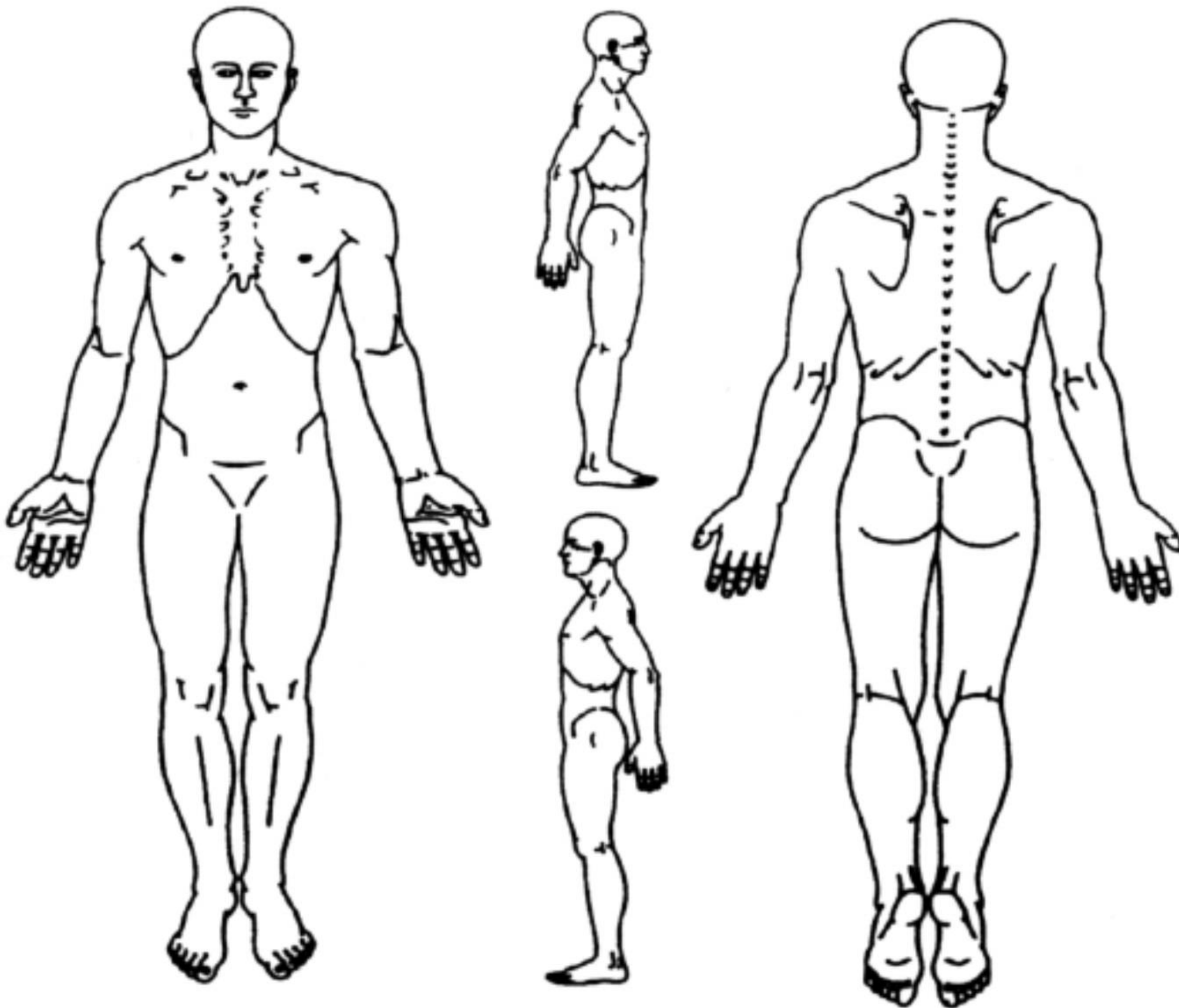
If your problem was left unhandled for five years, how do you think it would affect you? ___________________
____

Are you committed to getting rid of not only your symptom(s) but what has caused it, even if it requires a change in your lifestyle? (circle one) yes no

Do you have children? If so please tell me about them, names and ages? Are they healthy, do you have any health related concerns for them? ____
____
____

On the diagram below, please indicate where you are experiencing pain right now. Please mark the exact location of your pain on the diagrams using the following abbreviations:

Pain = P   Tingling = T   Numbness = N   Burning = B   Stiffness = S



Circle the severity of your pain on the scale of 0 – 10.

Extreme Pain										No Pain
10	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**0**

Please write any additional information you would like the Doctor to be aware of: ________

____

____

____

Patient Name: ______________________________ **Date:** ______________