East Detroit Chiropractic Center

Mediterranean Association, PLLC
35525 Garfield Rd, Ste B Clinton Twp, MI 48035-5521
(586) 477-1800 Fax: (586) 477-1815

Name_____Date_____

Preferred Name_____ Age_____ Birth Date_____

Marital Status: S M D W Height _____ Weight_____ Sex M F

Address_____

City_____ State_____ Zip Code_____

Telephone (_____)_____ Social Security #_____-_____-_____

Cell Phone (_____)_____ E-Mail _____

Race_____ Preferred Spoken Language_____

Preferred method of communications for patient reminders:

☐ e-mail ☐ home phone ☐ cell phone via text message

Occupation_____Work Phone__(_____)_____

Place of Employment_____

Address_____

Referred To Us By:_____Relationship_____

Employment Status:

☐ Employed ☐ Unemployed ☐ Full / ☐ Part Time Student ☐ Retired ☐ Disabled

With my signature below, I certify that I have completed this form accurately and completely to the best of my knowledge. I understand that though I may have health insurance coverage under a group health plan, Medicare, Workman's Compensation or personal injury-type policy, I am ultimately responsible for all charges of services rendered to me, should my claim be denied, disallowed, terminated, or payment not made in full by the insurance carrier for any reason. If I have no health coverage, payment is to be made in cash, as services are rendered. ***I understand that if I am divorced, the parent signing below for the child is financially responsible .***

I understand and agree all services rendered me are charged directly to me, and any health or accident insurance policies are between the insurance carrier and myself. This clinic will assist in preparing any necessary forms or reports in making collection of my account. **All x-rays are the property of this chiropractic clinic.** Should you require films for use outside this office, a disc copy will be made at a nominal fee and require a 24 hour notice.

_____

Date Signature of Patient, Parent of Patient (if minor child), or Legal Guardian

_____

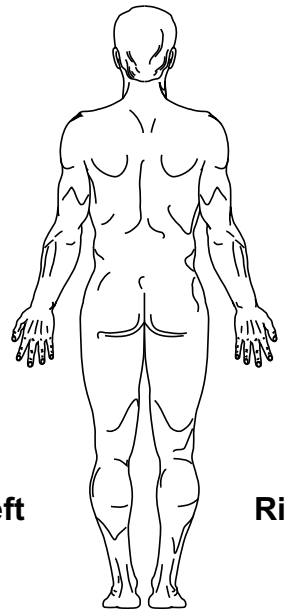
Date Signature of Parent, Spouse or Guardian Authorizing care

Pain Drawing

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
^^^^^^	=====	⊙⊙⊙⊙	. . . . .	//////////	XXXX
^^^^^^	=====	⊙⊙⊙⊙	. . . . .	//////////	XXXX

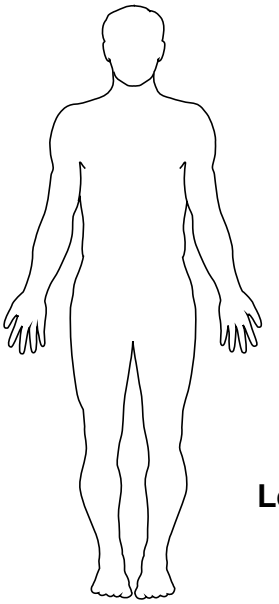
Draw the location of your symptom(s) on the body outlines:

Back



Left **Right**

Front



Right **Left**

Pain Scale: 0 = No pain 10 = worst possible pain

	0	1	2	3	4	5	6	7	8	9	10	constant	intermittent
Head	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neck	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Shoulder(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arm(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Upper back	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mid back	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Low back	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hip(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Leg(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Knee(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

How long have you been having the symptom(s)?

- ❍ 1 week or less
- ❍ 1 - 6 weeks
- ❍ 3 months - 1 year
- ❍ Over 1 year

How many times have you had this problem in the past?

- ❍ Never
- ❍ 1 - 3 episodes
- ❍ 4 or more episodes

When did you first have these or similar symptoms?

- ❍ Never
- ❍ Less than 6 months ago
- ❍ 6 months - 1 year ago
- ❍ More than 1 year ago

How would you describe your chief complaint at this time?_____
_____
_____

When did it start? Date_____
(Include at least the month and year, day if known)

What is the cause of this injury?_____

_____

What makes your symptom(s) worse?_____

What makes your symptom(s) better?_____

How would you describe your symptoms?_____

At what time of the day or week are your symptom(s) the worst?_____

Motor Vehicle Accident? ☐ YES ☐ NO

Job Injury? ☐ YES ☐ NO

Personal Injury? ☐ YES ☐ NO

Have you been to a chiropractor before? ☐ YES ☐ NO

Dr's Name_____ When seen_____

What results did you receive? (relief, moderate relief, no relief, etc.)_____

Have you been treated for today's condition by a M.D. or D.O.? ☐ YES ☐ NO

Dr's Name_____When seen_____

Diagnosis _____ Results_____

Are you taking any medication(s)? ☐ YES ☐ NO If yes, please provide list.

Are you allergic to any medication(s)? ☐ YES ☐ NO What kind, and reaction:_____

_____

Are you taking any self medications (aspirin, vitamins, herbal remedies, etc)? ☐ YES ☐ NO

If yes, list preparations used, amount used and for what purpose on medication(s) list.

Are you pregnant? ☐ Yes ☐ No If "Yes", when are you due? _____

Health Habits

Do you drink alcohol? ☐ Yes ☐ No

Do you use recreational drugs? ☐ Yes ☐ No If yes, are they narcotics? ☐ Yes ☐ No

Do you currently use tobacco? ☐ Yes ☐ No If no, are you are former smoker? ☐ Yes ☐ No

Are you exercising regularly either at home or a gym? ☐ Yes ☐ No

Work History

Briefly describe your job:_____

Are you able to work? ☐ YES ☐ NO

Are you primarily (check appropriate answers): ☐ Lifting ☐ Bending ☐ Twisting ☐ Turning ☐ Carrying ☐ Walking ☐ Arms Overhead

Work strain (physical): ☐ Light ☐ Moderate ☐ Heavy ☐ Strenuous

Work strain (mental): ☐ Light ☐ Moderate ☐ Heavy ☐ Strenuous

Activities of Daily Living	Going up or down Stairs	House and/or Yard Work	Lifting and/or carrying	Lying Down	Rising from seated position	Sitting	Sleeping	Stand	Walking
Can do without difficulty									
Can do with some difficulty									
Can do with great difficulty									
Can't do at all									

Past Health History

Please indicate the conditions that have been diagnosed, the year of the diagnosis and by whom. If you have doctors' addresses, please include them.		
Condition	Year	By Whom

Surgeries / Hospitalizations

Please indicate past surgeries or hospitalizations, the year of the surgery and/or hospitalization, and the name of the facility in which you were hospitalized.		
Surgery	Year	Facility

Health History

Please indicate current conditions by checking the corresponding box of the condition below:

General:
- ☐ fainting
- ☐ weight gain > 10 lbs
- ☐ nervousness
- ☐ fatigue
- ☐ numbness
- ☐ weight loss > 10 lbs
- ☐ sleep loss
- ☐ appetite loss
- ☐ headaches
- ☐ sweats
- ☐ forgetfulness
- ☐ dizziness
- ☐ fever

Eyes:
- ☐ blurred vision
- ☐ cataracts
- ☐ itching
- ☐ eye pain
- ☐ eye injury
- ☐ lack of tears
- ☐ loss of vision
- ☐ glaucoma
- ☐ double vision

ENT:
- ☐ hay fever
- ☐ persistent cough
- ☐ sinus problems
- ☐ hearing loss
- ☐ difficulty swallowing
- ☐ sleep apnea
- ☐ nose bleeding
- ☐ ringing in ears
- ☐ sore throat

Urinary:
- ☐ bladder infection
- ☐ hesitancy with urination
- ☐ bed wetting
- ☐ kidney stones
- ☐ blood in urine
- ☐ painful/frequent urination

Heart:	☐ abnormal cholesterol	☐ chest pain	☐ heart attack
	☐ pacemaker	☐ high blood pressure	
	☐ shortness of breath	☐ chest pressure when walking	
Lungs:	☐ asthma	☐ shortness of breath	
	☐ emphysema	☐ pneumonia	
Abdomen:	☐ acid reflux disease	☐ black or bloody stool	☐ constipation
	☐ excessive thirst	☐ hemorrhoids	
Skin:	☐ eczema	☐ history of cancer	
	☐ psoriasis	☐ bruise easily	☐ change in moles
Endocrine:	☐ excessive thirst	☐ unexpected weight gain	☐ excessive hunger
	☐ neck swelling	☐ unexpected weight loss	☐ dry skin
Neurological:	☐ dizziness	☐ insomnia	☐ balance problems
	☐ back pain	☐ fractures	☐ joint swelling or stiffness
Muscular/	☐ joint pain	☐ leg cramps	☐ tick bites
Skeletal:	☐ neck stiffness	☐ muscle pain	☐ sciatica
Male	☐ hernia	☐ prostate problems	☐ urinary difficulties
conditions:	☐ discharge from penis	☐ erection difficulties	☐ history of STD
	☐ lump(s) in testicles	☐ painful testicles	
Female	☐ breast lump(s)	☐ extreme menstrual pain	☐ hot flashes
conditions:	☐ history of STD	☐ vaginal discharge	☐ abnormal pap smear
	☐ bleeding between periods	☐ painful intercourse	
Social/	☐ suicidal ideas	☐ anxiety	☐ hard to concentrate/remember
Emotional:	☐ panic attacks	☐ depression	☐ loss of sexual interest
Hematology:	☐ abnormal blood count	☐ anemia	

Additional Comments:

_____

_____

_____

_____

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_____