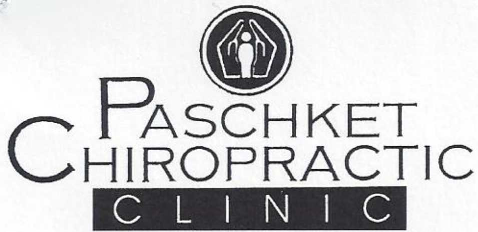


Phone (810) 659-2020

Case Number ______________________

Today's Date ______________________

__________ __________

Tell Us About You

Title: _______ First: ______________________ Middle ____ Last: ______________________

Nickname: ______________ Birth Date: __________ Age: ______ Sex: ❑ Male ❑ Female

Current address: ____

City: ______________________ State: ______ Zip: __________ SS# ______-______-________

Cell Phone: ______-______-________ Work Phone: ______-______-________ Ext: ______

Home Phone: ______-______-________ Preferred phone contact: ❑ home ❑ work ❑ cell

Email: ______________________________

Whom may we thank for referring you? ______________________________

Marital status: ❑ Single ❑ Divorced ❑ Widowed ❑ Married to: ______________________

# of children: __________ Ages of children: ______________________________

❑ Full-time employment ❑ Part-time employment ❑ Retired

Occupation: ______________________ Employer : ______________________

Emergency Contact: ______________________ Phone: ______-______-________

Emergency contact is your: ❑ Spouse/partner ❑ Parents ❑ Other : ______________________

What type of Insurance will be contributing to your care? ______________________________

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)? ______________________

The overall severity of your complaints/concerns is:

❑ Mild ❑ Mild to moderate ❑ Moderate ❑ Moderately severe ❑ Severe

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

On a scale of 0 to 10, how would you rate your pain/symptoms today? (please circle a number below)

None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible

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

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

Have you had recent treatment for this condition? ❑ No ❑ Yes-please list dates and doctors:

____

Have you had the same or similar problems in the past? ❑ No ❑ Yes - When: ____________

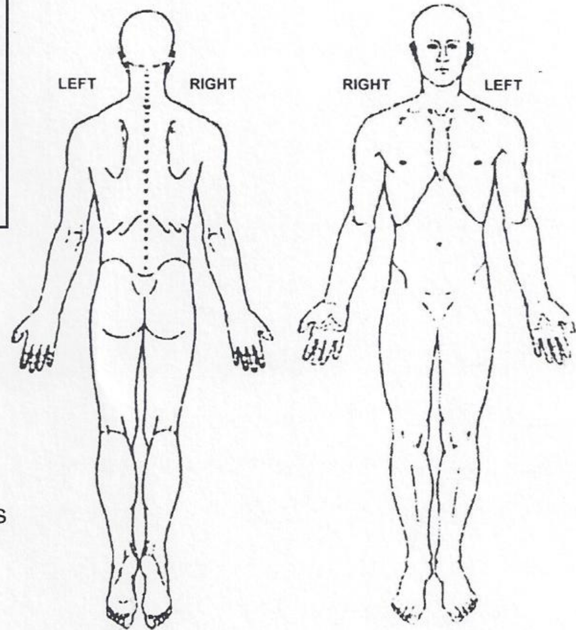
Do you have any additional complaints/concerns/health problems? ❑ No ❑ Yes-please describe:

____

____

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

Pain = **P**	Numbness = **N**	Weakness = **W**
Soreness = **0**	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

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

Your Activities of Daily Living and Work

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 in & 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**

❑ Other: ____

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: ______________

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: ______________

____

____

____

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 is your dominant hand: ❑ Left ❑ Right ❑ Ambidextrous

Which of the following best describes your stress level: ❑ None ❑ Minimal

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: ______________ per week

Are you currently taking any vitamins or nutritional supplements: ❑ No ❑ Yes-please indicate which one/s:

____

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: ______________

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: __________

Is there anything else you would like us to know? ❑ No ❑ Yes ______________

____

____

____

____

____

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 Paschket Chiropractic of any changes in my health status.

Signature: ____________________ Date: ______________ Case: ______________

Authorization, Assignment, Acknowledgment and Understanding

AUTHORIZATION TO RELEASE INFORMATION: Paschket Chiropractic is authorized to release any information that it deems appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Paschket Chiropractic, including its designated associates and assistants and hereby release Paschket Chiropractic from any consequence and/or liability concerning the same.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay directly to Paschket Chiropractic any monies due it on account, the same to be deducted from any settlement made on my behalf. Further, it is understood and agreed that I shall pay the full amount of the charges, should my condition be such that it is not covered by my insurance policy or if for any reason the insurance company and/or attorney refuses and/or fails to pay my claim.
UNPAID INSURANCE BALANCE: I understand and agree that should there be any unpaid insurance balance for sixty (60) days, such balance shall automatically become my responsibility.

MEDICARE ASSIGNMENT: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I authorize a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

CONSENT TO CARE FOR A MINOR: I hereby authorize Paschket Chiropractic to administer care as deemed necessary to: ____ .

OBLIGATIONS AS TO SERVICES: I hereby acknowledge that I am receiving (or about to receive) health care services at Paschket Chiropractic and that I have been advised that Paschket Chiropractic is willing to wait for payment for these services so long as there continues to be a likelihood that payment will be made either by my insurance company and/or out of the settlement of my liability case.

I understand and agree that, in the event that:

A. It is determined that there is no insurance company obligation to pay for Paschket Chiropractic's services;
B. The insurance company for the undersigned refuses to acknowledge an assignment to Paschket Chiropractic or to take other actions for the protection of the interest of Paschket Chiropractic;
C. My attorney fails and/or refuses to agree to protect the interest of Paschket Chiropractic as determined in its sole discretion; or
D. I fail to retain an attorney

then payment of services at Paschket Chiropractic will be made on a current basis and my bill paid in full within thirty (30) days from my last treatment.

COLLECTION: I acknowledge and agree that Paschket Chiropractic shall be entitled to reimbursement from me for any legal costs, including attorney fees, for all efforts to collect on any past due account with Paschket Chiropractic.
By my signature below, I make the foregoing authorizations, assignments and agreements.

______________________________	______________________________
Patient Name (Please Print)	Patient Signature
______________________________	______________________________
Date Signed	Witness