

(517) 543-2920
(517) 543-1221 Fax



432 N. Cochran Avenue
Charlotte, Michigan 48813

CONFIDENTIAL PATIENT INFORMATION

Date _____

Name _____ Social Security _____ Home Phone _____

Address _____ City _____ Zip Code _____

Age _____ Birth Date _____ Marital: M S W D How many children? _____

Occupation _____ Employer _____

Address _____ Work Phone _____

Name of Spouse _____ Occupation _____

Employer _____ Address _____

Patient's Nearest Relative _____ Address _____ Phone _____

Referred by _____

Is condition due to injury or sickness arising out of patient's employment? _____

Date symptoms appeared or accident happened: _____

Have you lost any days from work? _____

Date of last physical examination: _____ Female: Are you pregnant? _____

What operations have you had? _____

Serious illnesses? _____ Fractured bones? _____

Have you ever been under Chiropractic Care? Yes No Doctor's Name _____

Have you ever suffered from:

- Allergy
- Dizziness
- Fatigue
- Headaches
- Loss of sleep
- Ulcers
- Nervousness/Depression
- Numbness
- Arthritis
- Bursitis
- Foot trouble
- Low back pain

- Neck pain or stiffness
- Poor posture
- Sciatica
- Spinal Curvatures
- Swollen joints
- Colon trouble
- Diarrhea
- Difficult digestion
- Hemorrhoids
- Nausea
- Asthma
- Colds
- Deafness
- Ear noises
- Enlarged thyroid
- Eye pain

- Failing vision
- Tuberculosis
- Bruise easily
- Hay fever
- Nosebleeds
- Sinus infections
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Anemia
- Strokes
- Chest pains
- Difficulty breathing

- Pleurisy
- Swelling of ankles
- Cancer
- Varicose veins
- Bed-wetting
- Frequent urination
- Kidney infection or stones
- Prostate trouble
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Lumps in breast
- Alcoholism
- Diabetes
- Polio

Tingling or numbness in:

- Shoulders Hips
- Arms Legs
- Elbows Knees
- Hands Feet

HABITS:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____

DO YOU:

- Now take vitamins or minerals? Yes _____ No _____
- Think you may need vitamins or minerals? Yes _____ No _____
- Are you wearing: Heel lifts _____ Sole lifts _____
- Inner soles _____ Arch supports _____

