PATIENT INFORMATION:

Date _____

Name _____

Date of Birth _____

Email _____

Address _____ City _____State_____ Zip_____

Cell Phone _____ Home Phone _____Work Phone _____

Name of Spouse/Guardian _____ Spouse/Guardian Phone _____

Emergency Contact _____ Phone _____

Family Medical Doctor/Clinic_____

INSURANCE INFORMATION:

Insurance Company: _____

Adjuster's Name: _____

Adjuster's Phone Number: _____

Claim #: _____

ACCIDENT INFORMATION:

Date of the injury: _____/_____/_____

Time of the injury: _____ AM / PM

Name of your employer: _____

Address of your employer: _____

_____

Occupation: _____

Describe the incident in a few sentences:

_____

_____

_____

Did you report the incident to your supervisor? Yes ___ No ___

Supervisor's name: _____

Did your employer send you to a doctor? No ___ Yes ___ If yes, please provide the doctor's name

_____

Did you go to a doctor on your own? No ____ Yes ___ If yes, please provide the doctor's name

_____

Were any images taken? No____ Yes____ Circle all that apply.

X-ray MRI CT Ultrasound

Please list what part of the body images were taken: _____

Name of the facility the images were taken at: _____

Are there any other problems that affect your employment? No ____ Yes ____ If yes, please explain:

_____

_____

Does your job cause you to favor one side of your body? No ___ Yes ____ If yes, please explain: _____

_____

Before the injury, were you capable of performing equal work with others your age? Yes ___ No ____

Have you injured this area before? Yes ____ No ___ If yes, please explain: _____

_____

_____

INJURY INFORMATION:

What is injured from your accident/incident? _____

_____

Where does it hurt? Left? Right? Both sides? Other? _____

How would you describe your problem? Please circle all that apply.

Sharp	Shooting	Burning	Numb	Tingly
Dull	Achy	Sharp with Motion	Shooting with Motion	Stabbing with Motion

Other:_____

How often do you have this problem?

Constantly (75-100% of the time)	Frequently (50-75% of the time)	Occasionally (25-50% of the time)	Intermittently (Less than 25% of the time)

How would you rate the severity of your problem?

Mild	Moderate	Severe

Does your pain radiate anywhere in your body? If yes, please describe_____

_____

Do you have pain at night? If yes, please describe _____

_____

What makes your problem worse? Please circle all that apply.

Always there	Gardening	Shoveling	Standing up	Yard Work
Bending	Working Out	Sitting	Standing (long time)	Weather Changes
Driving	Lifting Objects	Sleeping	Stress	While at Work
Flexing/extending	Painting	Climbing Stairs	Computer Work	Sports:

Other, describe_____

What makes your problem better? Please circle all that apply.

Adjustments	Heat	Ibuprofen	Standing	Warm Bath
Bending Forward	Ice	Tylenol	Stretching	Nothing
Exercising	Massage	Rx Pain Medication	TENS/Muscle Stim	
Pain Relieving Cream	Muscle Relaxer	Resting	Walking	

Who have you seen for this problem? Please circle all that apply.

Chiropractor	ER Doctor	Massage Therapist	Physical Therapist
Neurologist	Orthopedist	Primary Care Doctor	No One

When and where? _____

For each of the conditions listed below, place a ✓ in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a ✓ in the "present" column.

PAST	PRESENT	SYMPTOM	PAST	PRESENT	SYMPTOM	PAST	PRESENT	SYMPTOM
		Headache			Rheumatoid Arthritis			Gallbladder disorder
		Neck pain			Cancer			Hepatitis
		Upper back pain			Benign tumor			Ulcer
		Mid back pain			Asthma			General fatigue
		Low back pain			Chronic Sinusitis			Visual disturbances
		Shoulder pain			High blood pressure			Dizziness
		Elbow/upper arm pain			Heart attack			Ringing in the ears
		Wrist pain			Chest pains			Diabetes
		Hip pain			Kidney stones			Frequent urination
		Upper leg pain			Kidney disorder			Drug dependence
		Knee pain			Bladder infection			Alcohol dependence
		Ankle/foot pain			Prostate problems			Depression
		Jaw pain			Weight gain/loss			Anxiety
		Joint pain/stiffness			Abdominal pain			Lupus
		Arthritis			Liver disorder			Epilepsy/seizures
		Loss of Sleep			Heartburn			Eczema/rash

Other_____

FAMILY HISTORY: (circle if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis F M S B	Cancer F M S B	Mental Illness F M S B
Diabetes F M S B	Asthma F M S B	Heart Disease F M S B
Arthritis F M S B	Kidney Disease F M S B	Lung Disease F M S B
Stroke F M S B	Liver Disease F M S B	Headaches F M S B
Low back pain F M S B	Neck Pain F M S B	Migraines F M S B

Other_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? **Yes** or **No** If yes, how much per week? _____

Have you ever used tobacco? **Yes** or **No** If yes, how much per day: _____

If a former tobacco user, date you quit _____

FEMALES ONLY: When was your last menstrual cycle? _____

Are you pregnant? No _____ Not Sure_____ Yes _____ Due Date: _____

Please ✓ if any of the following apply:

PAST	PRESENT	
		Birth control pill/patch, shot etc. Please specify:
		Hormone replacement: Describe
		Loss/termination of pregnancy:

Do you participate in any sports? Please circle all that apply.

Aerobics	Skiing	Basketball	Soccer	Baseball
Bicycling	Swimming	Football	Tennis	Golf
Lacrosse	Volleyball	Hockey	Walking	Softball
Running	Working Out	Martial Arts	Yoga/Pilates	Triathlons

Other_____

List any nutritional supplements you are taking (vitamins, herbs, naturopathic remedies, etc) _____
_____

Please list all surgical/hospitalizations you have had, including dates_____
_____
_____
_____

Do you have allergies of any kind? _____ No _____Yes If yes, describe: _____
_____

Have you had any PAST trauma (example: auto accident, work injury, broken bones/stitches)? Include dates:
_____
_____

Have you been treated for any health condition/any **other** health problems (no matter how insignificant they may seem be) by a physician in the last year? _____ No _____ Yes If yes, describe: _____
_____

PATIENT'S SIGNATURE: _____ **DATE:** _____

GUARDIAN'S SIGNATURE AUTHORIZING CARE: _____ **DATE:** _____

DOCTOR'S SIGNATURE: _____ **DATE:** _____

AUTHORIZED PEOPLE WHO HAVE ACCESS TO MY INFORMATION

I authorize Great Lakes Chiropractic of St. Michael to share my account information including TREATMENT DETAILS, ACCOUNT INFORMATION, PAYMENT DETAILS, AND APPOINTMENT TIMES with the following people. (spouse, parent, children)

_____ _____
NAME RELATIONSHIP TO PATEINT

_____ _____
NAME RELATIONSHIP TO PATEINT

_____ _____
NAME RELATIONSHIP TO PATEINT

☐ **Please do NOT allow anyone to access my information**

This is valid until revoked or changed by written communication.

_____ _____
SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY, IF MINOR) DATE