Chase Chiropractic Center
29050 Harper Ave. St. Clair Shores, MI 48081
586-774-0091 chasechiro.net clinic@chasechiro.net

Please complete this health history questionnaire as thoroughly as possible. The doctor requires this information prior to you beginning treatment, as it helps determine the best care to improve your health.

Patient Name: _____ Date: _____ Date of Birth: _____
Phone Number: _____ Occupation: _____
Marital Status: **Single Married Divorced Widowed** Email: _____
Current Health Complaint (reason for being seen today): _____
_____
_____
_____
_____
When did condition start? _____
What relieves condition? _____
What worsens condition? _____
Describe the pain (circle): **Dull Achy Sharp Stabbing Radiating Soreness Dizzy Burning**
Rate the severity of pain (circle): [none] **0 1 2 3 4 5 6 7 8 9 10** [severe]
Frequency of pain/condition (circle): **Occasional** 25% **Intermittent** 50% **Frequent** 75% **Constant** 100%
Have you been seen for this condition in the past?* **Yes No**
If yes, what doctor did you see? Name: _____
Address: _____
Phone Number: _____When were you seen? _____
List your diagnosis 1. _____ 2. _____ 3. _____ 4._____

***This information may be required by your insurance company if you have pre-existing clauses and limitation in your policy**

*Please circle **Yes** or **No** to indicate which conditions you have experienced within the last year*

Head/Neck:

Head Injuries	Yes	No	Skull Fracture	Yes	No	Unconscious	Yes	No
Head Aches	Yes	No	Ears Ringing	Yes	No	Dizziness	Yes	No
Hearing Loss	Yes	No	Ear Congestion	Yes	No	Ear Infection	Yes	No
Vision Loss	Yes	No	Blurred Vision	Yes	No	Stroke	Yes	No
Cataracts	Yes	No	Visual Floaters	Yes	No	Frequent Cold	Yes	No
Glaucoma	Yes	No	Teeth Grinding	Yes	No	Sinus Congest	Yes	No
TMJ/Jaw Pain	Yes	No	Facial Pain	Yes	No	Taste Loss	Yes	No
Light Sensitive	Yes	No	Neck Pain	Yes	No	Smell Loss	Yes	No
Sensitive Teeth	Yes	No	Neck Stiffness	Yes	No			
Neck Tension	Yes	No	Whiplash Injury	Yes	No			

Please explain any Yes answers: _____
_____
_____
_____

Chase Chiropractic Center
29050 Harper Ave. St. Clair Shores, MI 48081
586-774-0091 chasechiro.net clinic@chasechiro.net

Upper Extremities:

Hand Injury	Yes	No	Hand Pain	Yes	No	Hand Stiffness	Yes	No
Hand Tingling	Yes	No	Hand Numbness	Yes	No	Hand weakness	Yes	No
Wrist Injury	Yes	No	Wrist Pain	Yes	No	Wrist Stiffness	Yes	No
Wrist Tingling	Yes	No	Wrist Numbness	Yes	No	Wrist Weakness	Yes	No
Elbow Injury	Yes	No	Elbow Pain	Yes	No	Elbow Stiffness	Yes	No
Elbow Tingling	Yes	No	Elbow Numbness	Yes	No	Elbow Weakness	Yes	No
Shoulder Injury	Yes	No	Shoulder Pain	Yes	No	Shoulder Stiffness	Yes	No
Shoulder Tingling	Yes	No	Shoulder Numbness	Yes	No	Shoulder Weakness	Yes	No

Please explain any Yes answers: _____
_____
_____
_____

Thoracic Spine/Rib Cage:

Upper Back Pain	Yes	No	Upper Back Stiffness	Yes	No
Shoulder Blade Pain	Yes	No	Muscle Spasm	Yes	No
Pain With Breathing	Yes	No	Rib/Sternum Pain	Yes	No

Please explain any Yes answers: _____
_____
_____
_____

Cardiovascular/Respiratory System:

Irregular Heart	Yes	No	Asthma	Yes	No	Bronchitis	Yes	No
Shortness of Breath	Yes	No	Low BP	Yes	No	Murmur	Yes	No
Influenza	Yes	No	Heart Attack	Yes	No	High BP	Yes	No
Pneumonia	Yes	No	Rapid Heart	Yes	No	Chest Pain	Yes	No
Frequent Cough	Yes	No	Heavy Chest	Yes	No	Heart Disease	Yes	No

Please explain any Yes answers: _____
_____
_____
_____

Gastrointestinal/Urinary System:

Acid Reflux	Yes	No	Abdominal Pain	Yes	No	Abdominal Cramps	Yes	No
Bloating	Yes	No	Constipation	Yes	No	Colitis	Yes	No
Diarrhea	Yes	No	Ulcers	Yes	No	Difficulty Swallowing	Yes	No
Diabetes	Yes	No	Nausea	Yes	No	Freq. Vomiting	Yes	No
Hemorrhoids	Yes	No	Rectal Bleeding	Yes	No	Bladder Infect.	Yes	No
Kidney Infect.	Yes	No	Kidney Stones	Yes	No			

Chase Chiropractic Center
29050 Harper Ave. St. Clair Shores, MI 48081
586-774-0091 chasechiro.net clinic@chasechiro.net

Please explain any Yes answers: _____
_____
_____
_____

Reproductive System: Women Only

Incontinence	Yes	No
Frequent Urination	Yes	No
Painful Urination	Yes	No
Infertility	Yes	No
Irregular Cycle	Yes	No
Menopause	Yes	No
Severe Bleeding	Yes	No
Severe Cramping	Yes	No
Pregnancy Complications	Yes	No

Reproductive System: Men Only

Incontinence	Yes	No
Frequent Urination	Yes	No
Painful Urination	Yes	No
Difficult Urination	Yes	No
Impotence	Yes	No
Erectile Dysfunction	Yes	No

Please explain any Yes answers: _____
_____
_____
_____

Lower Back/Lower Extremity:

Disc Injury	Yes	No	Sciatica	Yes	No	Leg Cramp	Yes	No
Low Back Pain	Yes	No	Hip Pain	Yes	No	SI Injury	Yes	No
Low Back Stiffness	Yes	No	Hip Stiffness	Yes	No	Tailbone Injury	Yes	No
Low Back Tingling	Yes	No	Hip Weakness	Yes	No	Knee Pain	Yes	No
Low back Weakness	Yes	No	Leg Pain	Yes	No	Ankle Sprain	Yes	No
Low Back Tension	Yes	No	Leg Numb	Yes	No	Cold Feet	Yes	No
Low Back Numbness	Yes	No	Leg Tingle	Yes	No	Numb Feet	Yes	No

Please explain any Yes answers: _____
_____
_____
_____

General Health:
Have you ever been diagnosed with cancer? **Yes No** Explain: _____
_____
Do you have any skin conditions? **Yes No** Explain: _____
Do you have any infectious disease? **Yes No** Explain: _____

Rest/Energy/Exercise:
How many hours of sleep per night? _____
Do you wake feeling rested? _____

Chase Chiropractic Center
29050 Harper Ave. St. Clair Shores, MI 48081
586-774-0091 chasechiro.net clinic@chasechiro.net

Do you wake up during the night? _____ If yes, how often?_____
Do you have difficulty falling asleep? _____
Do you experience low energy levels? _____
Do you have episodes of fatigue? _____
List any exercise programs: _____

Stress Factors:
List the major stress factors in your life: _____
_____

Please circle **Yes** or **No** to indicate which conditions you have experienced within the last year:

Phobias	Yes	No	Depression	Yes	No	Anxiety	Yes	No
Low Motivation	Yes	No	Memory Loss	Yes	No			

Nutrition:
Are you on any specific diet? **Yes No** Explain: _____
List any dietary supplements: _____
Do you use (circle) nicotine, caffeine or alcohol? How much and how often? _____
_____
How many glasses of water do you drink daily? **0 1 2 3 4 5 6 7 8 9 10**
List any broken bones/fractures: _____
_____
_____
_____
List ALL surgeries/hospitalizations and dates: _____
_____
_____
_____
_____
List ALL accidents/injuries during your lifetime: _____
_____
_____
_____
_____
List major Diseases within your immediate family: _____
_____
_____
_____
_____
List ALL current prescription and over the counter medications: _____
_____
_____
_____
_____

Chase Chiropractic Center
29050 Harper Ave. St. Clair Shores, MI 48081
586-774-0091 chasechiro.net clinic@chasechiro.net

INFORMED CONSENT TO CHIROPRACTIC CARE

This constitutes informed consent for medical, physical therapy, and/or chiropractic care. I hereby request and consent to the performance of specific testing and procedures on me (or the patient named below for which I am legally responsible) as deemed necessary by the providing physicians at Chase Chiropractic Center. I understand, and am informed that, while extremely rare, there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, and strains. I wish to rely on the doctor and treating provider to exercise judgment during the course of the procedure, based on the facts then known is in my best interest. I have read, or have had read to me, the above consent. I have the opportunity to discuss the nature and purpose of the chiropractic adjustments and other procedures with the doctor and/or office personnel. I agree to these procedures and intend this consent form to cover the entire course of treatment and for any future condition(s) for which I seek treatment.

Initial _____

FINANCIAL AGREEMENT & APPOINTMENT POLICY

We, the staff at Chase Chiropractic thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship.

Understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service.

We ask for your assistance and cooperation in keeping your scheduled appointment date and time. It is Chase Chiropractic Center's policy that if the patient, no-shows or cancels an appointment with *less than 24 business hours' notice,* the patient will be charged a **$25.00 fee** (subject to change). If a need arises to cancel or change your appointment, please give the office a minimum of 24 hours' notice. Please note Monday appointments must be cancelled by 5pm on Friday.

We thank you for your cooperation and look forward to be a vital part of your recovery and maintenance.

Initial _____

Chase Chiropractic Center
29050 Harper Ave. St. Clair Shores, MI 48081
586-774-0091 chasechiro.net clinic@chasechiro.net

ACKNOWLEDMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES OF CHASE CHIROPRACTIC CENTER

I acknowledge that I was provided a copy of the Notice of Privacy Practices found in the office waiting room. I acknowledge that I have read them, or declined the opportunity to ready them, and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Chase Chiropractic Center to ensure the privacy of my personal health information. I understand that this will be placed in my member chart and maintained until my further notice.

Initial _____

Please list below names of relationships to people to whom you authorize Chase Chiropractic Center to release your private health information.

Print Name	Relationship
_____	_____
_____	_____
_____	_____

_____ _____
Signature/Guardian signature if under 18 Date

_____
Patient name (please print)