File #:__________
Date:__________

Family Chiropractic Healthcare Center, PLLC
3299 Clear Vista Ct Suite C Grand Rapids, MI 49525

Health Questionnaire: Please answer the following questions to the best of your ability.

Patient Demographic Information

Name:____
Last name *First name* *Middle Initial*

Address:____
City:______________________ State:__________ Zip Code:______________
Primary Phone Number: (___)______________ Alternate Number:(____)______________
Gender: □ Male □ Female Age:_______Date of Birth: ___/_____/________
Social Security Number:_____-_____-__________Driver's License #:________________
Email Address:________________________ Preferred Language: ________________
Ethnicity (Circle): Decline to Specify, Hispanic/Latino, Not Hispanic
Race (Circle): Decline to Specify, American Indian, Asian, Black, Pacific Islander, White

How were you referred to Family Chiropractic Healthcare Center?:__________________
Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated
Spouse/Partner's Name:______________________________________
Spouse/Partner's Phone:______________________________________
Other Nearest Relative or Contact Person:__________________ Phone:______________
If you are a minor, please state the name (s) of your parent(s) or legal guardian(s):____________
____

Other Healthcare Provider's Information

Primary Care Physician:__________________________ Date of last visit:______________
Have you received chiropractic care in the past? □ Yes □ No
Please give the date of your last visit, the name of the doctor, and the reason for the previous care:
____

Occupational History

Occupation: □ Working □ Retired □ Unemployed □ Student
Employer/School:__________________________________
Work Activity: □ Sitting □ Standing □ Twisting □ Bending □Light labor □Heavy labor
Have you ever been injured on the job:______________________________________

Medication(s): List ANY/ALL medications you are CURRENTLY taking. BE SPECIFIC

Medication	Dosage	For what condition?	Length of time taken

Allergies: List ALL allergies to medication(s) or other interactions. Specify reaction.

____
____

Supplements: List ANY/ALL non-prescription items you are CURRENTLY taking. BE SPECIFIC

Vit., Minerals, Herbs, etc...	Dosage	For what condition?	Length of time taken

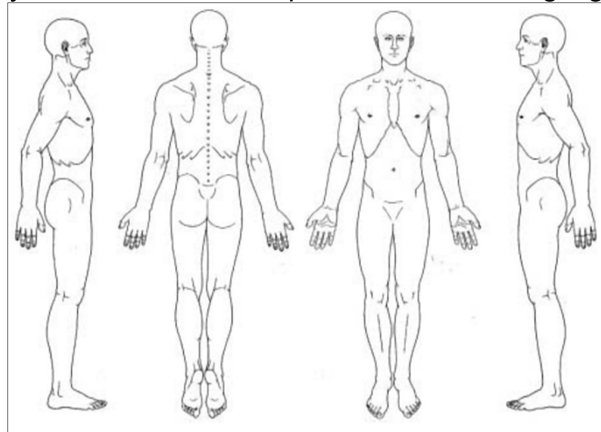
Personal & Family Health History

Have you ever been treated for a spine/nerve disorder: □ Yes □ No Explain:______________________
Date of Last:
Chiropractic Exam:_______________ X-Ray:__________________
MRI:_______________ Purpose:____
CT-Scan:___________ Purpose:____
Stool check for blood:_____________Colonoscopy:_____________Eye Exam:_______________
Do you currently wear or user any of the following:
□ Heel Lifts □ Innersoles □ Arch Supports □ Orthotics □ Braces □ Wraps □ Cane or crutch

Relation	*Alive/Deceased*	*Age(now/at death)*	*Significant illness / cause of death*
Father			
Mother			
Brother(s)/Sister(s)			

Patient Condition/Major Complaint(s) Information

Reason(s) for your visit today:____
____
Is this due to and accident? □ Yes □ No; □ Auto □ Work □ Home □ Other Date :_____________
When did your symptom(s) begin? __________________
Have you experienced these symptoms before? □ Yes □ No. When?___________________________
Is this condition getting: □ Better □ Worse □ Staying the same
What makes this condition worse:____
What makes this condition better:____
Does it interfere with your:
□ Work □ Sleep □ Self Care □ Daily Routine □ Recreation
Activities or movements that are difficult/painful to perform:
□ Lying on back □ Getting in/out of car □ Sleeping □ Stooping □ Standing for a long time
□ Lying on side □ Gripping/reaching □ Pushing □ Sitting □ Sneezing
□ Turning over □ Climbing □ Pulling □ Bending □ Coughing
□ Lying flat □ Dressing □ Washing □ Walking □ Sexual Activity
What treatment(s) have you already received for your condition?
□ Chiropractic □ Medications □ Surgery □ Physical Therapy □ None □ Other:
Name of other doctor(s) who has treated you for this condition:_________________________________
Were you Satisfied: □ Yes □ No
Mark your pain on the below scale 0 to 10:
(At rest) No Pain ☺ 1 2 3 4 5 6 7 8 9 10 Extreme Pain/ No Function
(With Activity)No Pain ☺ 1 2 3 4 5 6 7 8 9 10 Extreme Pain/ No Function
Mark on the picture where you continue to have pain, numbness, tingling, etc...



Child & Adult Illness(es); List all past health conditions. Indicate if any are still present.

____
____
____

Surgery(ies): List all Surgical Procedures with the date of the procedure was performed.

____
____
____
____
____

Injury (ies): List all injuries. Write the date of the injury immediately afterward and explain.

____
____
____
____
____

Social History:

Are you on any special diet? □ Yes □ No If yes, for what reason:___________________________________

Have you gained or lost over 10lbs in the past six months without trying? □ Yes □ No

Tobacco Use: Now? □ Yes □ No Amount /week How long?___________Years/months

□ Quit Date:________________

Do you currently engage in recreational drug use? □ Yes □ No

Do you have any concerns about your sexual health? □ Yes □ No

Are you or have you ever been a victim of domestic or sexual abuse? □ Yes □ No

Review of Systems

Female: Mark all that apply below

I... □ AM CURRENTLY PREGNANT □ AM CURRENTLY NOT PREGNANT

Menstrual History: Age of first menses:______________ Date of last menses:___/___/_____

I...□ Currently have menses □ Currently DO NOT have menses

My menses... □ Are regular □ Are NOT regular

If you have been pregnant in the past, please fill in the appropriate information below:

_______ # of complicated pregnancies_______ # of C-sections_______ # of vaginal deliveries

□ Birth Control □ Cramps □ Hormone therapy □ Urine Retention □ Frequent Urination

Male: □ Check this box if you have NO symptoms/problems in this category

□ Burning Urination □ Frequent Urination □ Prostate Problems □ Erectile Dysfunction □ Hesitancy/Dribbling

Constitutional:□ Check this box if you have NO symptoms/problems in this category

□ Chills □ Fatigue □ Night sweats □ Weight Loss □ Daytime Drowsiness □ Fever □ Weight Gain

Eyes/Ears/Nose/Throat: □ Check this box if you have NO symptoms/problems in this category

□ Poor Vision
□ Blurred Vision
□ Cataracts
□ Change in vision
□ Pain in the eyes
□ Nosebleeds
□ Nasal obstruction
□ Sinusitis
□ Nasal Congestion
□ Sore Throat
□ Deafness
□ Earache
□ Ear Discharge
□ Wear Glasses/Contacts:
Type of correction:_________________
□ Thyroid problems
□ Frequent colds
□ Ringing in ears

Patient's Initials:_____

Respiration: □ Check this box if you have NO symptoms/problems in this category

□ Asthma □ Coughing up blood □ Shortness of Breath □ Wheezing □ Chest Pain □ Chronic cough
□ Rib fracture □ Other:

Allergy: □ Check this box if you have NO symptoms/problems in this category

□ Anaphalaxis □ Itching □ Sneezing □ Food Intolerance □ Nasal Congestion □ Rash

Psychological: □ Check this box if you have NO symptoms/problems in this category

□ Anxiety □ Bi-polar Disorder □ Depression □ Behavior Change □ Confusion □ Insomnia □ Memory Loss

Cardiovascular: □ Check this box if you have NO symptoms/problems in this category

□ Angina (chest pain/discomfort after exertion) □ Palpitations (heart flutter) □ Chest Pain
□ Claudication (leg pain/ache) □ Heart Murmur □ Shortness of breath □ Varicose Veins
□ Hypertension(High Blood Pressure) □ Hypotension (Low Blood Pressure) □ Swelling of legs
□ Other:

Gastrointestinal: □ Check this box if you have NO symptoms/problems in this category

□ Abdominal Pain □ Difficulty Swallowing □ Nausea □ Vomiting Blood
□ Belching □ Heartburn □ Constipation □ Vomiting
□ Hemorrhoids □ Diarrhea □ Abnormal Stool: Color/Character/Consistency/Amount

Endocrine: □ Check this box if you have NO symptoms/problems in this category

□ Cold Intolerance □ Excessive Thirst □ Abnormal Frequency of Urination □ Hair Growth
□ Diabetes □ Heat Intolerance □ Voice Changes □ Excessive Hunger □ Hair Loss
□ Goiter □ Thyroid

Skin/allergies: □ Check this box if you have NO symptoms/problems in this category

□ Changes in Nail Texture □ Hair Loss □ Itching □ Changes in Skin Color □ Rash
□ Hair Growth □ History of Skin Problems □ Skin Lesion/Ulcer

Nervous System: □ Check this box if you have NO symptoms/problems in this category

□ Dizziness □ Loss of Memory □ Stress
□ Facial Weakness □ Numbness □ Stroke
□ Headache □ Seizures □ Tremor
□ Limb Weakness □ Sleep Disturbances □ Uncontrollable Bowel/Bladder
□ Loss of Consciousness □ Slurred Speech □ Unsteadiness of Gait/Balance

Do you have or have you had any of the following Diseases
□ Check this box if you have NO symptoms/problems in this category

□ Appendicitis □ Epilepsy □ Pleurisy □ Pneumonia □ Mental disorder
□ Cancer □ Chickenpox □ Whooping cough □ Influenza □ Diabetes
□ Polio □ Eczema □ Arthritis □ Tuberculosis □ HIV
□ Alcoholism □ Heart disease □ Venereal disease □ Anemia □ Rheumatic Fever

As healthcare providers we are concerned about your overall wellness.
On future visits we will discuss issues with you that may impact your overall health.

All of the answers I have given are correct to the best of my knowledge, and I agree to have an examination performed at Family Chiropractic Healthcare Center, PLLC at this time.

______________________________ ____________
Patient's Signature Date

______________________________ ____________
Signature of Parent or Legal Guardian Relationship

Patient's Initials:_____

Family Chiropractic Healthcare Center, PLLC

3299 Clear Vista Ct. Suite C
Grand Rapids, MI 49525
Phone (616) 363-7713 Fax (616) 363-4958

Personal Financial Responsibility For Care

I understand and agree that if I have health and/or accident insurance policies, that these policies are an arrangement between my insurance company and myself. Any amount paid to this office will be credited to my account upon my receipt. I understand that my insurance policies may cover part, or none of the services rendered. I clearly understand and agree that all services rendered to me are my personal responsibility.

Cancellation Policy

Late cancellations of less than 24 hours and patients who do not show for a scheduled appointment will be charged $45.00. We do not accept walk-in appointments.

How would you like to be reminded of your appointments (Please only pick 1)

□ I would like to be reminded the day before my appointment via text message

Cell Phone #:________________________________ Carrier: ________________________

□ I would like to be reminded the day before my appointment via email

Email Address:_____________________________________

□ I do not need to be reminded of my appointment

Authorization To Pay Doctor Directly

I authorize the direct payment to my doctor from my insurance company that is contractually obligated to pay my doctor directly out of any proceeds of any settlement I may receive. A photocopy of this form is acceptable for this authorization.

Authorization To Release Patient Information

I authorize this office to release any information requested by a third party that presents a signed release bearing my signature.

I have read, fully understand and agree to abide by the above policies

Printed Name: ____ Date:______________

Signature: ____ CA:______________

____ _______________

Signature of Parent or Legal Guardian Relationship

Patient's Initials:_____

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Notice of Your Privacy Rights

I acknowledge that Family Chiropractic Healthcare Center provides the opportunity to review the Notice of Privacy Practices. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation at Family Chiropractic Healthcare Center. The Notice of Privacy Practices for Family Chiropractic Healthcare Center is also provided on request at the main administration desk. The Notice of Privacy Practices also describes my rights and Family Chiropractic Healthcare Center's duties with respect to my protected health information.

Family Chiropractic Healthcare Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a copy or by asking for one at the time of my next appointment.

Printed Name: ___________________________________ Date: _______________

Signature: _____________________________________ CA: ________________

____ ____________________
Signature of Parent or legal Guardian Relationship

I hereby give permission to discuss my case and financial information with the following individuals:

Name	Relationship