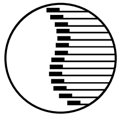

White Lake Chiropractic Life Centre

1030 S MEARS, STE. A • WHITEHALL, MICHIGAN 49461 • (231) 893-1755

Date	Patient I.D. #

Patient Health History

Name: ______________________ Age: ________ Date of Birth: ______________________ Sex: ❑M ❑F

Address: ______________________ City: ____________ State: ________ Zip: ____________

Phone (Home): ____________ (Work) ____________ Marital Status: ❑S ❑M ❑D ❑W Number of Children: ________

Occupation: ______________________ Social Security Number: ______________________

Employer: ______________________ Driver's License Number: ______________________

Spouse's Name: ______________________ Spouse's Age: ________ Spouse's Date of Birth: ____________

Spouse's Occupation: ______________________ Spouse's Social Security Number: ______________________

Spouse's Employer: ______________________ Spouse's Phone (work): ______________________

Insured's Name: ______________________ Insured's Phone: ______________________ Insured's Date of Birth: ________

Insurance Company: ______________________ Spouse's Insurance Company: ______________________

How did you hear about this office? ______________________ Referred by: ______________________

Past Chiropractic Care: ❑Yes ❑No When? ____________ Doctor's Name: ______________________ Results: ____________

Are your present problems due to an injury? ❑Yes ❑No ❑On Job ❑Auto Accident ❑Personal Injury ❑Other: ____________

Has the accident been reported? ❑Yes ❑No ❑To Employer ❑Auto Carrier ❑Other: ______________________

Are you now or have you ever been disabled (Service or Work)? ❑Yes ❑No When? ______________________

Have you retained an attorney? ❑Yes ❑No Name and Address: ______________________

What is your current work status?

❑Full time, no restrictions ❑Full time, restrictions ❑Full time Homemaker ❑Full time student

❑Part time, no restrictions ❑Part time, restrictions ❑Retired ❑Unemployed

❑Off work due to restrictions ❑Other ______________________

Restrictions:

Off work: ❑Yes ❑No ❑Previously From: ____________ to ____________

Light Duty: ❑Yes ❑No ❑Previously (If Yes, what are/were your restrictions?) ______________________

Do/did you require outside help at home?

❑Yes ❑No (If Yes, what help do/did you need?) ______________________

List any accidents or falls and dates: ❑Auto: ____________ ❑Recreation: ____________

❑Sports: ____________ ❑Work Related: ____________ ❑Other: ____________

List any broken bones (fractures) or dislocations: ______________________

Ever on crutches? ❑Yes ❑No Why? ______________________

Were you ever knocked unconscious? ❑Yes ❑No (If yes, please explain): ______________________

Have you ever had X-rays taken? ❑Yes ❑No When? ______________________

For what aliments were those X-rays made? ______________________

Do you wear orthotics or heal lifts? ❑Yes ❑No Fitted by whom? ____________ When? ____________

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No ____________

Are you presently taking any medications, prescription, over-the-counter, home remedies, vitamins, minerals, etc?

Please list: ______________________

OPERATIONS AND PROCEDURES

❑I have never had any operations or surgeries

DATE		DATE		DATE	
____________	Vaccinations	____________	Spinal Taps/Injections	____________	Sinus
____________	Tonsillectomy	____________	Appendectomy	____________	Hernia
____________	Gall Bladder	____________	Female Organs	____________	Thyroid
____________	Back Operation	____________	Rectal Surgery	____________	Stomach

Other ______________________

(over)

Please check the following for each item below. Check at least one box for each sign or symptom listed. ❑Never ❑Previously ❑Presently

Never	Previously	Presently	GENERAL SYMPTOMS
❑	❑	❑	Allergy(What) ______ ________________
❑	❑	❑	Bronchitis
❑	❑	❑	Convulsions
❑	❑	❑	Dizziness
❑	❑	❑	Fainting
❑	❑	❑	Fatigue
❑	❑	❑	Headache
❑	❑	❑	Loss of Sleep
❑	❑	❑	Loss of Weight
❑	❑	❑	Nervousness
❑	❑	❑	Night Sweats
❑	❑	❑	Numbness or pain in arms/legs/hands
❑	❑	❑	Wheezing

Never	Previously	Presently	GASTRO-INTESTINAL
❑	❑	❑	Belching or Gas
❑	❑	❑	Colon Trouble
❑	❑	❑	Constipation
❑	❑	❑	Diarrhea
❑	❑	❑	Gall Bladder Trouble
❑	❑	❑	Hemorrhoids (piles)
❑	❑	❑	Jaundice
❑	❑	❑	Liver Trouble
❑	❑	❑	Nausea
❑	❑	❑	Stomach Pain
❑	❑	❑	Vomiting
❑	❑	❑	Vomiting Blood
❑	❑	❑	Heart Burn
❑	❑	❑	Bloody Stools
❑	❑	❑	Acid Reflux
❑	❑	❑	Irritable Bowel

Never	Previously	Presently	EYE/EAR NOSE/THROAT
❑	❑	❑	Asthma
❑	❑	❑	Deafness
❑	❑	❑	Earache
❑	❑	❑	Ear Discharge
❑	❑	❑	Ear Noises
❑	❑	❑	Thyroid Problems
❑	❑	❑	Frequent Colds
❑	❑	❑	Hay Fever
❑	❑	❑	Nasal Obstruction
❑	❑	❑	Nose Bleeds
❑	❑	❑	Pain in Eyes
❑	❑	❑	Poor Vision
❑	❑	❑	Blurred Vision
❑	❑	❑	Sinusitis
❑	❑	❑	Sore Throats
❑	❑	❑	Tonsillitis

Never	Previously	Presently	RESPIRATORY
❑	❑	❑	Chest Pain
❑	❑	❑	Chronic Cough
❑	❑	❑	Difficulty Breathing
❑	❑	❑	Spitting Blood
❑	❑	❑	Spitting Phlegm

Never	Previously	Presently	GENITO-URINARY
❑	❑	❑	Bed Wetting
❑	❑	❑	Blood in Urine
❑	❑	❑	Frequent Urination
❑	❑	❑	Inability to Control Urine
❑	❑	❑	Kidney Infection
❑	❑	❑	Kidney Stones
❑	❑	❑	Painful Urination
❑	❑	❑	Prostate Trouble

Never	Previously	Presently	MUSCLES & JOINTS
❑	❑	❑	Backache
❑	❑	❑	Foot Trouble
❑	❑	❑	Hernia
❑	❑	❑	Pain Between Shoulders
❑	❑	❑	Painful Tail Bone
❑	❑	❑	Stiff Neck
❑	❑	❑	Spinal Curvature
❑	❑	❑	Swollen Joints
❑	❑	❑	Tremors
❑	❑	❑	Twitching

Never	Previously	Presently	CARDIO-VASCUALR
❑	❑	❑	High Blood Pressure
❑	❑	❑	Low Blood Pressure
❑	❑	❑	Chest Pain
❑	❑	❑	Heart Trouble
❑	❑	❑	Poor Circulation
❑	❑	❑	Rapid Heart
❑	❑	❑	Slow Heart
❑	❑	❑	Strokes
❑	❑	❑	Swelling Ankles
❑	❑	❑	Varicose Veins

Never	Previously	Presently	SKIN OR ALLERGIES
❑	❑	❑	Bruising Easily
❑	❑	❑	Dryness
❑	❑	❑	Eczema
❑	❑	❑	Hives or Allergy
❑	❑	❑	Itching
❑	❑	❑	Sensitive Skin
❑	❑	❑	Skin Eruptions

Never	Previously	Presently	FOR FEMALES ONLY
❑	❑	❑	Cramps
❑	❑	❑	Hot Flashes
❑	❑	❑	Irregular Cycles
❑	❑	❑	Painful Periods
❑	❑	❑	Vaginal Discharge

❑Yes❑No Pregnant at this time

_________ Last Pap Date

_________ Last Menstrual Cycle

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑ Appendicitis	❑ Anemia	❑ Heart Disease	❑ Arthritis	❑ Pneumonia	❑ Measles
❑ Goiter	❑ Epilepsy	❑ Rheumatic Fever	❑ Mumps	❑ Influenza	❑ Mental Disorder
❑ Polio	❑ Chicken Pox	❑ Pleurisy	❑ Lumbago	❑ Tuberculosis	❑ Diabetes
❑ Alcoholism	❑ Eczema	❑ Whooping Cough	❑ Cancer	❑ Venereal Disease	❑ HIV Positive

HABITS

❑Smoking	Packs/Day: _______
❑Drinking	Alcohol: (Cups/day) _____
❑Coffee	Cups/day: ________
❑Soft Drinks	Bottles or cans/day _______
❑Water	Cups/day: _________

EXERCISE

❑None
❑Moderate
❑Daily
Type_________
____

FAMILY HISTORY

	Diabetes	Kidney	Cancer	Back
Mother	❑	❑	❑	❑
Father	❑	❑	❑	❑
Brother(s) # of ____	❑	❑	❑	❑
Sister(s) # of _____	❑	❑	❑	❑

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider will prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and give authority for these procedures to be performed. It is understood and agreed that amount paid to the Doctor for imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: ____ Date: ___________________________________