23200 Greater Mack Ave
Saint Clair Shores, MI 48080
greaterchiromi@gmail.com
p: (586) 334-5300

# NEW PATIENT PAPERWORK

*Thank you for trusting our office with your chiropractic needs. Please use ink while completing the following forms. If you have any questions, please do not hesitate to ask for assistance, we will be more than happy to help!*

**Name:** _____ **Date:** _____

**Date of Birth:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Cell Phone:** _____ **Home Phone:** _____

**How did you hear about us?** _____

## HEALTH INSURANCE INFORMATION

Please present your **insurance card(s)** and **Driver License** to the Front Desk to be copied. (If you were involved in an **Auto Accident**, please confirm with the Front Desk which insurance carrier is primarily responsible for your claim).

**Name of Insurance Carrier** _____

**Policy Number** _____ **Group Number** _____

**Enrollee ID**_____

**Name of Insured (if different than patient)** _____

**Date of Birth** _____ **SS#** _____-_____-_____

**Relationship to Patient** _____

## EMERGENCY CONTACT (If available):

**Name:** _____**Relationship:** _____

**Phone Number:** _____

## SYMPTOMS:

**Where is your pain located?**_____

**Does this pain radiate? If so, where?** _____

**Check all the following that describe your pain:**

| | | | |
|---|---|---|---|
| ☐ Aching | ☐ Sharp | ☐ Hot/Burning | ☐ Heavy |
| ☐ Tiring | ☐ Shooting | ☐ Gnawing | ☐ Tender |
| ☐ Cramping | ☐ Fearful | ☐ Throbbing | ☐ Stabbing |
| ☐ Sharp | ☐ Exhausting | ☐ Sickening | ☐ Weakness |

GREATER CHIROPRACTIC

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**What word best describes the frequency of your pain?**

❑ Infrequent (0-25%) ❑ Occasional (25-50%) ❑ Frequent (50-75%) ❑ Constant (75-100%)

**When is your pain at its worst?** ❑ Mornings ❑ During the day ❑ Evenings

❑ After activity ❑ Middle of the night ❑ With movement

**Approximately, when did this pain begin?** _____

**What caused your current pain episode?** _____

**Is your pain the result of a Motor Vehicle Accident or Personal Injury?** ❑ Yes ❑ No

**How did your current pain episode begin?** ❑ Gradually ❑ Suddenly

**Since your pain began, how has it changed?** ❑ Decreased ❑ Increased ❑ Stayed the same

**What makes the pain better?** _____

**What makes it worse?** _____

**Any other associated problems you would like to address?** _____

_____

**Use the following pain descriptions to help us understand your pain better.**

| | |
|---|---|
| 1-4 | Pain that does not prevent you from participating and completing daily activities |
| 5 | Pain that makes you feel you need medication, but does not force you to stop your activity |
| 6-7 | Pain that is severe enough to stop any task and necessitates immediate medication |
| 8-9 | Pain so severe and debilitating that someone else has to get your medications for you |
| 10 | Absolutely the worst pain. You are completely disabled. |

How much do you hurt ***right now***? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑10

At its ***worst*** in the last 24 hours? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

At its ***least*** in the last 24 hours? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

How much do you hurt on ***average?*** ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

## HEALTH HISTORY

**Are you currently taking any of the following medications?**

❑ Nerve Pills ❑ Pain Killers (ex. Aspirin) ❑ Stimulants ❑Blood Thinners ❑ Insulin

❑ Other Medications: _____

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## Have you ever had any of the following diseases and/or medical condition(s)?

**EYES, EARS, NOSE, THROAT**

❑ Vision Problems ❑ Earaches ❑ Nasal Drainage/Sore Throat

**CONSTITUTIONAL/SYSTEMIC**

❑ Weight Gain/Loss ❑ Fatigue ❑ Fever
❑ Cancer ❑ Shingles

**CARDIOVASCULAR**

❑ Heart Attack ❑ Heart Surgery/ Pacemaker ❑ Heart Murmur
❑ Mitral Valve Prolapse ❑ Congenital Heart Defect ❑ Artificial Valves
❑ Phlebitis ❑ High blood pressure ❑ Chest discomfort
❑ Angina ❑ Shortness of breath ❑ Passing out
❑ Palpitations or flutters ❑ Swelling of the ankles ❑ Heart valve disease
❑ Congestive heart failure ❑ Leg pain while walking ❑ Varicose veins
❑ Murmur ❑ Blood clots ❑ High/ Low Blood Pressure
❑ Difficulty breathing when lying down ❑ Wake up at night short of breath
❑ Elevated cholesterol, Triglycerides, lipids

**RESPIRATORY**

❑ Emphysema ❑ Asthma ❑ Difficulty Breathing
❑ Tuberculosis ❑ Sinus Problems

**GASTROINTESTINAL**

❑ Indigestion ❑ Ulcers/Colitis ❑ Constipation
❑ Diarrhea/Loose Stools ❑ Irritable Bowel Syndrome ❑ Hiatal Hernia

**GENITOURINARY**

❑ Kidney Disease ❑ Venereal Disease ❑ Sexual Dysfunction
❑ Prostate Issues ❑ Menstrual Problems

**MUSCULOSKELETAL**

❑ Lower Back Pain ❑ Artificial Bones/ Joints ❑ Arthritis
❑ Frequent Neck Pain ❑ Fusions ❑ Rheumatic Fever

**NEUROLOGICAL**

❑ Severe/ Frequent Headaches ❑Stroke ❑Fainting/ Seizures/ Epilepsy

**PSYCHIATRIC**

❑ Anxiety ❑ Depression ❑ ADD/ADHD
❑ Psychiatric Disorder(s)_____ ❑ Alcohol/ Drug Abuse

**ENDOCRINE**

❑ Diabetes ❑ Thyroid Problem ❑_____

**HEMATOLOGY/LYMPHATIC**

❑ Hepatitis ❑ HIV/AIDS ❑ Anemia

**OTHER:** ❑_____ ❑_____ ❑_____

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**Do you smoke or use tobacco products?** YES ☐ NO ☐

**If yes, how many years have you smoked or used tobacco products?** _____

**Are you currently taking Birth Control?** YES ☐ NO ☐

**Are you pregnant?** YES ☐ NO ☐ **If yes, how far along?** _____

**List any other serious medical condition (s) you have currently or have had in the past:**

_____
_____
_____

**List any allergies you have:**

_____
_____
_____

**List all previous surgeries/ hospitalizations/ treatments (include dates)**

_____
_____
_____

**List any or all past accidents with dates and details: If within last year alert front desk**

_____
_____
_____

**Has anyone in your family suffered from any serious diseases/ medical conditions?**

**YES** ☐ **NO** ☐ If yes, please explain:

_____
_____
_____

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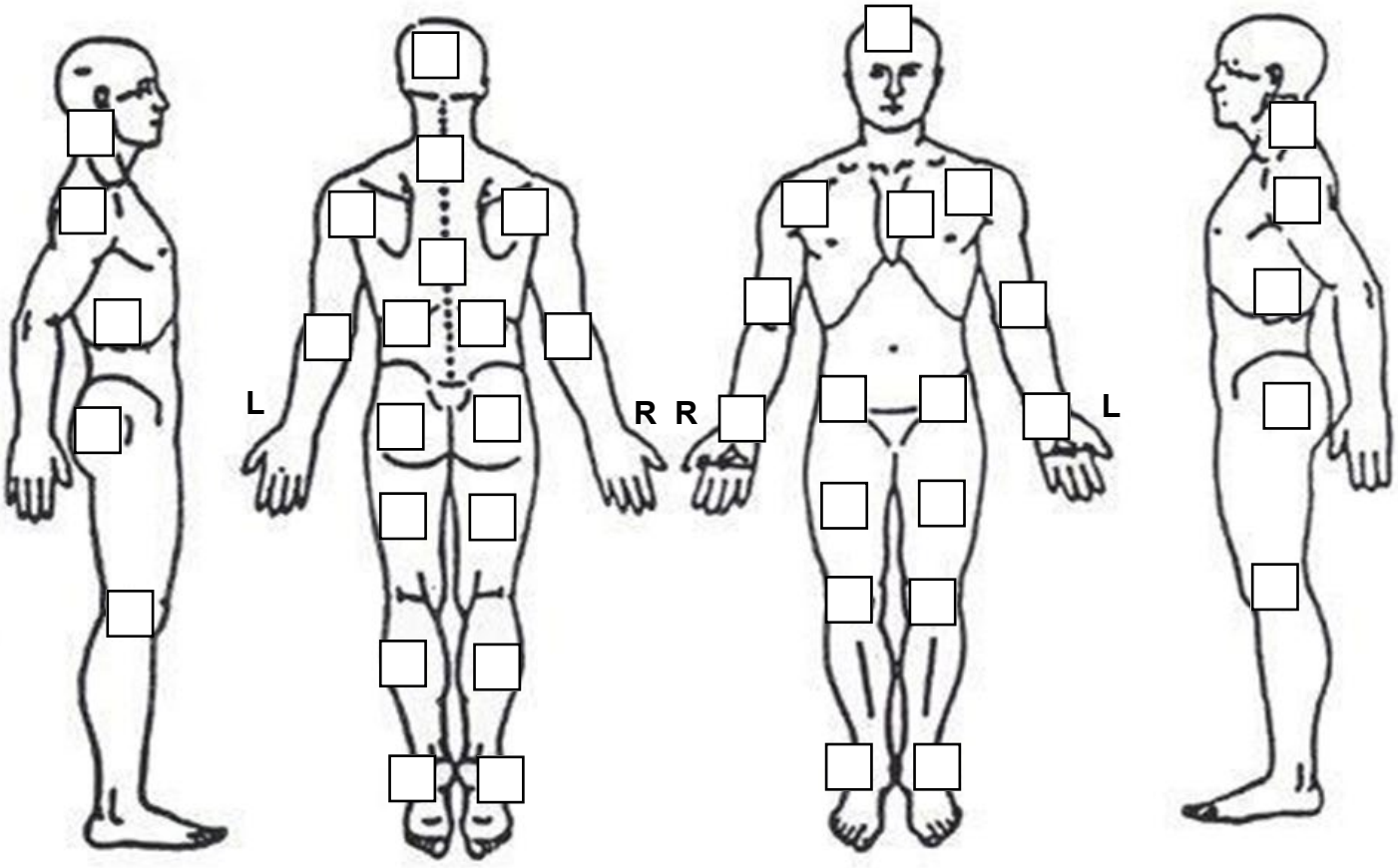
**Indicate the location and type of your pain.**
**Mark the diagram with and X at the site of your problem:**




**RIGHT SIDE** **BACK** **FRONT** **LEFT SIDE**

*****BEFORE MOVING ON*****

## Have you been involved in an AUTO ACCIDENT in the last year?

☐ **YES** ☐ **NO**

**IF YES**: Please alert the front desk staff