21641 Allen Rd., Woodhaven, MI 48183 Tel: (734) 362-7500
www.siegelclinic.com

PATIENT INFORMATION

Patient Name: ____ **Birthdate**: _____/_____/_______
Social Security #:____________________**Sex**: _____M _____F
Marital Status (check): _____Single _____Married_____Divorced _____Minor _____Other

Address:____________________________**City**:_______________________**State**:_____**Zip**:__________
Occupation:________________________________**Employer/School**:_____________________________
Home Phone #: _____________________________**Cell Phone #**:
____
Email: _______________________________________
Would you like text or email reminders? _______Cell phone service provider:______________________
Emergency Contact: ___________________**Relationship**:_____________**Phone#**: __________________

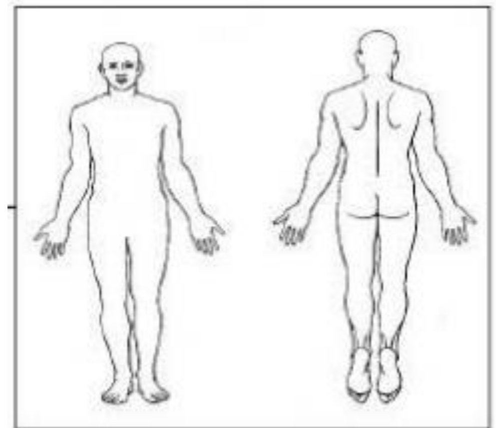
Referred by: ____

REVIEW

Insurance carrier (if applicable): __________________________
Who is financially responsible for this account?______________ *If other than self, please provide additional info*
Name/Subscriber: ____**Birthdate**: _____/_____/_______

Reason for Visit: ____
Is your condition the result of an accident (check)? ____No ____Yes Work Injury? ____No ____Yes
When did your symptoms start to appear? ____
Is this condition getting progressively worse (check)? _____No_____Yes _____Unknown
Have you had chiropractic services in the past (check)? _____No_____Yes

Mark an X on the picture where you continue to have pain, numbness or tingling.



Circle the severity of your pain on a scale from 0 - 10 (least-severe).
0 1 2 3 4 5 6 7 8 9 10

Type of pain (check):
_____Sharp _____Dull _____Throbbing_____Numbness
_____Aching _____Shooting_____Burning_____Tingling
_____Cramps_____Stiffness_____Swelling_____Other

How often do you have this pain? ______________________
Is it constant or does it come and go? ____
Does it interfere with your (check):
_____Work _____Sleep_____Daily Routine_____Recreation
Activities or movements that are painful to perform (check):
_____Sitting _____Standing_____Walking_____Bending_____Laying down_____Laying on side

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MEDICAL HISTORY

Please list off any current medications: ____

Please list off past surgical history (include all dates):______________________________________

____

Past illnesses of yourself or family: Circle or indicate family members.

If none please initial here: _______________

YOU/FAMILY	YOU/FAMILY	YOU/FAMILY
Alcoholism_______________	Heart Disease _______________	Scoliosis ___________________
Anemia _________________	High Blood Pressure __________	Stroke _____________________
Asthma _________________	Kidney Disease ______________	Suicide Attempt ______________
Cancer/Tumor ___________	Liver Disease ________________	Thyroid Disease ______________
Drug Abuse______________	Hepatitis ____________________	Tuberculosis, TB _____________
Depression_______________	Mental Illness ________________	High Cholesterol ______________
Diabetes(Type1/2)_________	Osteoarthritis ________________	HIV/Immune DX ______________
Epilepsy/Seizures_________	Osteoporosis ________________	Covid-19____________________
Glaucoma ______________	Rheumatic Arthritis ___________	Other: _____________________

Review of Systems- Please circle all that apply as they relate to your health.

If none please initial here: _______________

CONSTITUTIONAL
Weight Loss
Fatigue
Fever

EYES
Glasses/Contacts
Eye Pain
Double Vision
Cataracts

EAR, NOSE, THROAT
Difficulty Hearing
Ringing in Ears
Vertigo
Sinus Trouble
Nasal Stuffiness
Frequent Sore Throat

CARDIOVASCULAR
Murmur
Chest Pain
Palpitations
Dizziness
Fainting Spells
Shortness of Breath
Difficulty Laying Flat
Swelling Ankles

RESPIRATORY
Cough
Coughing Blood
Wheezing
Chills

GASTROINTESTINAL
Heartburn/Reflux
Nausea/Vomiting
Constipation
Jaundice
Abdominal Pain
Black or Bloody BM
Diarrhea

GENITOURINARY
Burning/Frequency
Nighttime
Blood in Urine
Erectile Dysfunction
Abnormal Discharge
Bladder Leakage

PSYCHIATRIC
Anxiety/Depression
Mood Swings
Difficult Sleeping

ALLERGIC/IMMUNOLOGIC
Hives/Eczema
Hay Fever

HEMATOLOGY/LYMPH
Easy Bruising
Gums Easily Bleed
Enlarged Glands

MUSCULOSKELETAL
Joint Pain/Swelling
Stiffness
Muscle Pain
Back Pain

SKIN
Rash/Sores
Lesions
Itching/Burning

NEUROLOGICAL
Loss of Strength
Numbness
Headaches
Tremors
Memory Loss

ENDOCRINE
Loss of Hair
Heat/Cold Intolerance

FEMALES ONLY
Currently Pregnant
Number of pregnancies: ______

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim. I also request the payment of government benefits either to myself or to the party who accepts assignment below.

DATE: ___________________ **SIGNED**: ____