BRACKNEY CHIROPRACTIC HEALTH CENTERS PLLC
8524 Canton Center Canton, MI 48187
(734) 455-4444

NEW PATIENT FORM

"Your Lifetime Family Wellness Center!"

Date _______

Name:________________________________ Address______________________________________
City:_________________________________ State:___________ Zip/Postal Code:_______________
Home Phone:(____)_____________________ Birth Date:_____________ Age______ Sex: ❑ M ❑ F
Cell Phone:(____)______________________ Work Phone:(_____)____________________________
Email:________________________________ Social Security Number________-______-_________
Choose One: ❑Married ❑Single ❑Widowed ❑Divorced
Business Employer:______________________ Type of Work:________________________________
Name of Spouse________________________ Spouse's Employer_____________________________
Referred To This Office By _____________________
Names and Ages of Children ____
Name and Number of Emergency Contact:____
Relationship____
Who Is Responsible For Your Bill, You and ❑ Spouse ❑Auto Insurance ❑Medicare ❑Workers' Comp.
❑Personal Health Insurance (Name) __________________________❑Health Card #_____________
Insured Person's Name______________________________________ Date of Birth _______________

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CURRENT HEALTH CONDITION

Unwanted Health Condition(s):____
Other Doctors Seen For This Condition ❑ Yes ❑ No` Who?_________________________________
Type of Treatment:__________________________________ Results: _________________________
When Did This Condition Begin? ____________________ Has This Condition Occurred Before? ❑ Yes ❑No
Is the Condition ❑ Job Related ❑ Auto Accident ❑ Home Injury ❑ Fall ❑ Other:______________________
Date of Accident: _________________________________ Time of Accident: ________________________
Have You Made a Report to Your Employer : ❑ Yes ❑ No
Medications You Currently Take: ❑ Pain Killers/Muscle Relaxers ❑ Nerve Pills ❑ Blood Pressure Medicine
❑ Insulin ❑ Other: ____
Do You Wear a Shoe Lift? ❑ Yes ❑ No
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _______________
____

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PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ❑ Appendectomy ❑ Gall Bladder ❑ Hernia ❑ Cardiac Surgery ❑Disc Surgery ❑Back/Neck Spinal Surgery ❑ Broken Bones ❑ Other_____________________________

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Name _____Date_____

Major Accidents or Falls: _____

_____

Hospitalization (Other Than Above): _____

_____

Previous Chiropractic Care ❑ None ❑ Doctor's Name and Approximate Date of Last Visit _____

CHECK OFF ANY OF THE FOLLOWING DISEASES YOU HAVE HAD/HAVE:

❑ Arthritis
❑ Epilepsy
❑ Cancer
❑ Mental Disorders
❑ Diabetes
❑ Anemia
❑ Heart Disease
❑ Other _____

Have you ever tested positive for HIV ❑ Yes ❑ No

DAILY INTAKE:

❑ Coffee
❑ Tea
❑ Alcohol
❑ Cigarettes
❑ White Sugar

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

❑ Neck Pain
❑ Pain Across Top of Shoulders
❑ Pain Between Shoulders
❑ Low Back Pain
❑ Joint Pain
❑ Arm/Leg Pain
❑ Joint Stiffness
❑ Difficulty Walking
❑ General Stiffness
❑ Headaches

NERVOUS SYSTEM

❑ Stress
❑ Numbness
❑ Paralysis
❑ Dizziness
❑ Forgetfulness
❑ ADD/ADHD
❑ Easily Confused
❑ Depression
❑ Seizures/Convulsions
❑ Tingling Extremities
❑ Fatigue
❑ Loss of Sleep
❑ Fever

GENITO-URINARY

❑ Bladder Problems
❑ Painful/Frequent Urination
❑ Kidney Stones/ Infections

C-R-V

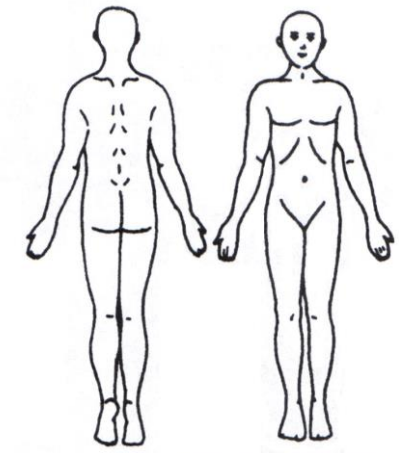
❑ Stroke
❑ Chest Pain
❑ Short Breath
❑ Blood Pressure Problems
❑ Irregular Heartbeat
❑ Heart Problems
❑ Lung Problems/Congestion
❑ Ankle Swelling

EENT

❑ Allergies
❑ Sore Throat
❑ Vision Problems
❑ Ear Aches
❑ Stuffed Nose
❑ Hearing Difficulty

MALE/FEMALE

❑ Menstrual Cramps
❑ Prostrate/Sexual Dysfunction
❑ Menstrual Irregularity
❑ Breast Pain/Lumps
❑ Other_____



Please outline on the diagram the area of your discomfort

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Name _____Date_____

GASTRO-INTESTINAL

- ❑ Poor/Excessive Appetite
- ❑ Excessive Thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea/ Constipation
- ❑ Hemorrhoids
- ❑ Heart Burn
- ❑ Liver Problems
- ❑ Gall Bladder Problems
- ❑ Weight Trouble
- ❑ Abdominal Cramps
- ❑ Gas Bloating After Meals

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ❑ Mother
- ❑ Father
- ❑ Brother
- ❑ Sister
- ❑ Spouse
- ❑ Child

FEMALES ONLY:

When was your last period?_____

Are you pregnant?

❑ Yes ❑No ❑ Not Sure

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. The Doctor's Office will prepare any necessary reports and forms for the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited on my account receipt.

I understand:
If my insurance policy requires a co-pay or co-insurance, it is due at the time of service.
If I have not satisfied my yearly deductible, I may have to pay for the services rendered today.
That having an insurance policy is not a guarantee of benefits.
If my insurance policy does not cover the services rendered today, or I do not have an insurance policy, I am financially responsible.
I agree to keep a credit card on file. I understand that I may be billed for services rendered.
All policies as outlined above. **Initial**: _____

I hereby authorize the doctor to discuss my case with me and perform necessary examinations/tests. It is understood and agreed the amount paid the Doctor for x-rays is for, the actual taking of, examination of and interpretation of, the X-rays. The X-ray negatives will remain property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred in this office.

Patient's Signature _____Date_____
Guardian or Spouse's
Signature Authorizing Care _____Date_____

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Name_____Date_____

SPINAL HEALTH QUESTIONNAIRE

1. I have pain
__None at all
__Occasionally
__Intermittently
__Continuously

2. My pain is
__Mild
__Moderate
__Severe

3. I can sit
__Not at all
__Only with pain
__Only for a short period of time before pain begins
__For a moderate amount of time before pain begins
__As long as I wish

4. I can drive
__Not at all
__Only with pain
__Only for a short period of time before pain begins.
__For a moderate period of time before pain begins.
__As long as I wish

5. I can stand
__Not at all
__Only with pain
__Only for a short period of time before pain begins.
__For a moderate period of time before pain begins.
__As long as I wish

6. I can bend
__Not at all
__Only with pain
__Only for a short period of time before pain begins.
__For a moderate period of time before pain begins.
__As long as I wish

7. I can lift
__Not at all
__Only light weights (1-10)
__Moderate weights (11-30)
__Heavy weights (31 or more)

8. I can walk
__Not at all
__Only with pain
__Only for a short period of time before pain begins.
__For a moderate amount of time before pain begins.

9. My sleep is
__Undisturbed
__Lightly disturbed (1-2 hrs sleepless)
__Moderately disturbed (2-4 hrs sleepless)
__Severely disturbed (4 or more hrs sleepless)

10. I am currently working
__Not at all
__Light duties
__Regular duties

11. I am able to Perform my Job duties
__Not at all
__Partially
__Completely

12. I am able to Perform household Duties
__Not at all
__Partially
__Completely

13. I need attendant Care
__Yes
__No