CANTON CHIROPRACTIC LIFE CENTER

43050 FORD RD STE 140 ❁ CANTON, MI 48187 ❁ 734-981-8210 PHONE ❁ 734-981-8212 FAX

PLEASE PRINT Email_____

PERSONAL INFORMATION

NAME_____ DATE_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE_____SOC. SEC. NO._____ DATE OF BIRTH_____

MARITAL STATUS_____SEX_____AGE_____NUMBER OF CHILDREN_____

OCCUPATION_____EMPLOYER_____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

NAME OF SPOUSE_____ SPOUSE'S OCCUPATION_____

EMPLOYER_____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

EMERGENCY NOTIFICATION

NAME _____

ADDRESS_____CITY/ZIP_____TELEPHONE_____

REFERRED BY_____

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the $20 returned check charge in the event that my check is returned.
Date_____ Patient's Signature_____

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES
I hereby authorize Canton Chiropractic Life Center to release any information required in the course of my examination or treatment necessary to satisfy medical insurance claims.
Date_____ Patient's Signature_____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT_____

HOW DID IT HAPPEN? _____

TODAYS CONDITION STARTED WHEN?_____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?_____

WHAT ACTIVITIES LESSEN YOUR CONDITION? _____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY?_____

IS THIS CONDITION INTERFERING WITH WORK?_____ SLEEP?_____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE?_____

OTHER DOCTORS SEEN FOR THIS CONDITION_____

TYPE OF TREATMENT_____RESULTS_____

Habits

- ❑ Alcohol: Type_____
  Amount_____
  Diet: Salt intake_____
  Fat intake_____
  Other_____
- ❑ Sleep:Difficulty falling asleep_____
  Continuity disturbances_____
  Early morning awakenings___
  Daytime drowsiness_____
  Other_____
- ❑ Smoking: Packs daily_____
  How long_____
  Interested in stopping?_____
- ❑ Exercise routine:____
  _____
- _____
- ❑ Caffeine: Coffee, cups daily_____
  Other_____

❑ Ringing In Ear_____
❑ Ear Infections - *Frequent* _____
❑ Dizziness/Fainting _____
❑ Failing Vision _____
❑ Eye Infections _____
❑ Nose Bleeds_____
❑ Sinus Trouble _____
❑ Sore Throats - *Frequent* _____
❑ Hayfever/Allergies _____
❑ Pneumonia _____
❑ Bronchitis/Chronic Cough_____
❑ Asthma/Wheezing _____
❑ Chest Pain _____
❑ High Blood Pressure _____
❑ Heart Murmur _____
❑ Swollen Ankles _____
❑ Leg Pain - *Walking*_____
❑ Varicose Veins/Phlebitis _____
❑ Loss of Appetite _____
❑ Difficulty Swallowing _____
❑ Indigestion or Heartburn _____
❑ Persistent Nausea/Vomiting _____
❑ Peptic Ulcers _____
❑ Abdominal Pain - *Chronic*_____

❑ Gall Bladder Trouble _____
❑ Jaundice/Hepatitis _____
❑ Change in Bowel Habits _____
❑ Diarrhea ❑ Constipation _____
❑ Diverticulosis ❑ Crohn's/Colitis ___
❑ Bloody or Tarry Stools _____
❑ Hemorrhoids _____
❑ Hernia _____
❑ Urine Infections - *Frequent* _____
❑ Blood In Urine _____
Urination-❑ Overnight > than twice
❑ Painful ❑ Loss of Control
❑ Decrease in Force/Flow
❑ Kidney Stones _____
❑ Venereal Disease_____
❑ Urethral Discharge _____
❑ Chronic Fatigue _____
❑ Weight Loss - *Recent* _____
❑ Anemia ❑ Bruise Easily _____
❑ Cancer _____
❑ Diabetes _____
❑ Thyroid Disease _____
❑ Convulsions/Seizures _____
❑ Stroke _____

❑ Tremor/Hands Shaking _____
❑ Muscle Weakness _____
❑ Numbness/Tingling Sensations ____
❑ Headaches - *Frequent* _____
❑ Arthritis/Rheumatism _____
❑ Osteoporosis _____
❑ Back Pain - *Recurrent* _____
❑ Bone Fracture/Joint injury _____
❑ Gout _____
❑ Foot Pain ❑ Cold Numb Feet ____
❑ Rashes ❑ Hives _____
❑ Psoriasis ❑ Eczema_____
❑ Nervousness ❑ Depression_____
❑ Memory Loss _____
❑ Moodiness - *Excessive* _____
❑ Phobias _____
❑ Mental Illness_____
❑ Lactose Intolerance _____
❑ Prostate Disease _____
❑ Sexual/Menstrual Dysfunction ____
❑ Frequent Infections _____
❑ Diphtheria _____
❑ Tetanus _____
❑ Chicken Pox ❑ Polio ❑ Mumps ❑ Measles ❑ Rubella ❑ Rheumatic Fever
❑ Scarlet Fever ❑ Tuberculosis ❑ Herpes
❑ Other _____
❑ Other _____

Females - *Please Complete*
Pregnant? ❑ Yes ❑ No
Planning Pregnancy? ❑ Yes ❑ No
Menstrual Flow:
❑ Regular ❑ Irregular ❑ Pain/Cramps
___Days of Flow ___Length of Cycle
Date-1st day of last period_____
❑ Pain/Bleeding during or after sex
Number of:
___Pregnancies ___Abortions
___Miscarriages ___Live Births
Birth Control Method_____
B.C. Pill (Name) _____
❑ Flushing/Menopause
Date of Last PAP Test _____
❑ Normal ❑ Abnormal
Date of Last Mammogram
❑ Normal ❑ Abnormal

MEDICATIONS:_____

DRUG ALLERGIES:_____

Medical History

HOSPITALIZATIONS:

Date	Reason	Date	Reason

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FAMILY MEMBER
FATHER				DIABETES	
MOTHER				CANCER	
BROTHERS AND SISTERS	_____ _____ _____	_____ _____ _____	_____ _____ _____	BLOOD DISEASE GLAUCOMA EPILEPSY	_____ _____ _____
SPOUSE				RHEUMATOID ARTHRITIS	
CHILDREN	_____ _____ _____	_____ _____ _____	_____ _____ _____	TUBERCULOSIS GOUT HIGH BLOOD PRESSURE	_____ _____ _____
				HEART DISEASE	
				BACK PROBLEMS	