



MICHALSKI CHIROPRACTIC WELLNESS CENTRE, S.C.

CONFIDENTIAL PATIENT INFORMATION

(Please Print)

Personal Information

Full Name _____ Date _____

Mailing address _____

Street City State Zip

Home Phone () _____ Work Phone () _____

Cell Phone () _____ E-MAIL _____

Best time and place to contact you _____

Social Security # _____ Drivers License # _____

Spouse/Guardian Name _____

Marital Status: M S W D Age _____ Birth date _____ No. of children _____

Pregnant? _____ Height _____ Weight _____ Occupation _____

Employer's Name and Address _____

Spouse Occupation/Employer _____

Name of person responsible for account _____

Do you have insurance that covers Chiropractic care? Yes _____ No _____

Do you have Medicare Coverage? Yes _____ No _____

Name of Insurance Company _____ Group/Policy # _____

Address _____ Phone _____

WHO MAY WE THANK FOR REFERRING YOU? _____

ADDRESSING WHAT BROUGHT YOU INTO THIS OFFICE:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History" section

I. HEALTH CONCERNS

List health concerns according to their severity	Rate of severity 1= mild 10= worst imaginable	When did this episode start?	If you had the condition before, when?	Did problem begin with an injury?	% of time pain is present
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

What have you done for this condition? Was it of benefit?

I do (do not) have a family history of this or similar symptoms (Please explain)

What activities aggravate your condition? _____

Other Doctor's seen for this condition: _____

Did it help? _____

Is this condition interfering with your: work _____ sleep _____ daily routine _____ sports/exercise _____

Other _____

II. GENERAL HEALTH HISTORY SECTION

Have you had any surgery? (Please include all surgery) Please indicate spinal surgery first

- 1. Type _____ When _____ Doctor _____
2. Type _____ When _____ Doctor _____
3. Type _____ When _____ Doctor _____
4. Type _____ When _____ Doctor _____

Have you had more than 4 surgeries? ___Yes ___No

Accidents and/or injuries: auto, work related, or other (Especially those related to your present problems).

- 1. Type _____ When _____ Hospitalized ___Yes ___No
2. Type _____ When _____ Hospitalized ___Yes ___No
3. Type _____ When _____ Hospitalized ___Yes ___No

Have you ever had x-rays taken? _____ When? _____ Where? _____

Area of body: _____

Do you wear orthotics or heel lifts? Yes ___ No ___

CURRENT MEDICINE(S)/SUPPLIMENTS:

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Do you take any nutritional supplements daily? How many? (This will be evaluated on a future visit) ___Yes I'm interested!

III. PAST HEALTH HISTORY:

Mark the following conditions you may have had or have now (- have had +have now)

- ___ Allergy ___Diarrhea ___Measles ___Rheumatic Fever ___Alcoholism ___Eczema
___ Miscarriage ___Stroke ___Anemia ___Multiple Sclerosis ___HIV (Aids) ___Gout
___Arteriosclerosis ___Emphysema ___Mumps ___Sinus Problems ___Arthritis ___Neuritis
___High Blood Pressure ___Asthma ___Nervousness ___Thyroid Problems ___Ulcers ___Cancer
___Heart Disease ___Depression ___Convulsions ___Venereal Disease ___Malaria ___Pleurisy
___Constipation ___Pneumonia ___Cold Sores ___Whooping Cough ___Polio ___Neck Pain
___Gall Bladder Problems ___Migraines ___Headaches ___Menstrual Cramps ___Back Pain ___Epilepsy
___Irregular Periods ___Diabetes ___Tuberculosis ___Heart Attack
___Low Blood Sugar ___Ringing in ears ___Other (please explain) _____

Please list your top three stresses in each category:

- 1. Physical stress (falls, accidents, work postures, etc.)
a. _____
b. _____
c. _____
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
a. _____
b. _____
c. _____
3. Psychological stress (work, relationships, finances, self-esteem, etc.)
a. _____
b. _____
c. _____

How do you grade your physical health? Excellent___ Good___ Fair___ Poor___ Getting better___ Getting worse ___

How do you grade your emotional/mental health? Excellent___ Good___ Fair___ Poor___ Getting better___ Getting worse ___

Is there anything else which may help to better understand you which has not been discussed?

Why are you here at this point in time?_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment at the time of service and cannot defer payment to a later date. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition, as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and 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 at this office.

I understand that Michalski Chiropractic Wellness Centre, S.C. reserves the right to charge \$30.00 for appointments cancelled or broken without 15 minutes advance notice

Patient's Signature _____ Date _____

Consent to Treat a Minor _____ Date _____

Guardian of Spouse's
Signature of Authorizing Care _____ Date _____