



Madison Heights Chiropractic Center

28107 John R Madison Heights, MI 48071

248-542-3492

OFFICE PROCEDURE & PATIENT INFORMATION

Welcome to the Madison Heights Chiropractic Center. This clinic is a full service analytic and rehabilitative facility, offering some of the most advanced and sophisticated equipment available.

The Madison Heights Chiropractic center specializes in structural and nerve related conditions, spinal manipulations, disc regeneration techniques, nutrition, and rehabilitative care, with a holistic approach to body-health relationships. This clinic recognizes that spinal structural alignment, nerve interference, and disc conditions all play a significant role in the maintenance of the healthy body. We attempt to be as conservative as possible in our approach to health care, and want our patients to understand their particular problem. Therefore, we will sit down with you, after the exam, and explain what is wrong and what must be done to improve your condition.

This Clinic accepts patients for treatment in the following ways:

1. **Acute** - (Not complex or chronic in nature, with no involved examination findings) The patient is treated on a visit-by-visit basis, or unit of care.
2. **Chronic/Complex** - (Conditions which have not responded to other forms of treatment or shown by examination to be complex, long standing, and require greater attention) Patient is accepted on a stabilization basis. Treatment is determined on the severity of the condition and what needs to be done. Fees are proportional to the complexity of the problem and may be paid on a visit-by-visit basis or special arrangement. If examination reveals appropriate findings, then the possibility of a Neurosurgical consultant or other health practitioner must be considered.
3. Nutritional supplements, post manipulative soft tissue techniques, disc reduction for reduction for regeneration, realignment and expansion, adjust rehabilitative intermittent intersegmental traction, rehabilitative exercise programs, and spinal stabilization supports may also be recommended.

Please indicate your desires below and fill out the information on the attached form.

Type of Service Desired

- _____ 1. Temporary Relief
- _____ 2. General Stabilization
- _____ 3. Specific Correction if Possible
(Optimum Healthcare)

How Would You Classify Your Condition?

- _____ 1. Minor
- _____ 2. Involved
- _____ 3. Fairly Severe & Progressively Getting Worse
- _____ 4. Serious & would like to know the cause and correction.

PERSONAL INFORMATION

Date _____ Social Security No. _____

Patient Name _____ Male ___ Female ___ Other ___
(last) (first) (middle initial)

Address _____ City _____ State _____ Zip _____

Email _____

(Email is required for Patient Portal Access)

Cell Phone _____ Home Phone _____ Are you Pregnant? YES NO Unsure

Date of Birth _____ Age _____
(month) (day) (year)

Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Number of Children _____

Name of Spouse _____ Name of Children _____

Patient's Occupation or Profession _____

Employed by _____ Business Phone _____

Is the above patient under the age of 18? ___ No ___ Yes If Yes, Parent/Guardian please complete line below:

Name _____ Relationship _____ SSN# _____

Address _____ Phone _____

Primary Care Physician (PCP) Name _____ Phone Number _____

Date of your last visit with your PCP & Yearly Physical: _____

Past Surgeries _____

How did you hear about our office? **Referred by** _____

Have you had an X-Ray/MRI/CT (circle) done within the past year? YES / NO Where? Neck Mid-Back Low Back

Have you had chiropractic before? _____ Where? _____

Have you had Pain Management: ___ Current ___ Previous ___ Never

Do you have health insurance? No Yes If yes: _____ Policy# _____

Do you have any of the following(circle): HSA FSA None

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? IF YES, MARK "X"

(This applies to current symptoms as well as those that you have experienced in the past, from birth to present day)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Acid Reflux/Heartburn | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> <i>Marfans</i> | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> <i>Ehlers-Danlos (Type IV)</i> | <input type="checkbox"/> Menstrual Cramps and Pain | <input type="checkbox"/> Shooting Head Pain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Shoulder Tightness |
| <input type="checkbox"/> Base of Neck Pain | <input type="checkbox"/> <i>Fibromuscular Dystrophy</i> | <input type="checkbox"/> Mid Back Pain when Sleeping | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> <i>Balance/Coordination Problems</i> | <input type="checkbox"/> Gall Bladder Trouble | <input type="checkbox"/> Migraines | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Bladder Troubles | <input type="checkbox"/> Head Feels Heavy | <input type="checkbox"/> Muscle Spasms in Mid/Low Back | <input type="checkbox"/> Stiff Mid Back |
| <input type="checkbox"/> <i>Bleeding Disorders</i> | <input type="checkbox"/> Headaches | <input type="checkbox"/> Muscle Spasms in Neck | <input type="checkbox"/> Stiff Neck |
| <input type="checkbox"/> <i>Blood in Urine or Stool</i> | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Nausea or Upset Stomach | <input type="checkbox"/> Stomach Disorder |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> <i>Strokes</i> |
| <input type="checkbox"/> <i>Bruising Easily</i> | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> <i>Numbness/Weakness of head or face</i> | <input type="checkbox"/> Swollen Joints |
| <input type="checkbox"/> Bulging Disc | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Numbness of Arm or Hand | <input type="checkbox"/> Throbbing Head Pain |
| <input type="checkbox"/> Bypass Surgery | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Numbness of Legs or Feet | <input type="checkbox"/> Thyroid Trouble |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> <i>Hypertension/HBP</i> | <input type="checkbox"/> <i>Nystagmus/Rapid Eye Mov't</i> | <input type="checkbox"/> Tingling in Fingers |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> <i>Lightheadedness</i> | <input type="checkbox"/> Pain in Shoulder Blades | <input type="checkbox"/> Trouble Bending |
| <input type="checkbox"/> <i>Chronic Lung Disease</i> | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Pain into feet | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Clicking or Grinding in Neck | <input type="checkbox"/> Inner Tension | <input type="checkbox"/> Pain into Legs | <input type="checkbox"/> <i>Trouble Speaking (Speech)</i> |
| <input type="checkbox"/> Cluster Headaches | <input type="checkbox"/> Intestinal Gas | <input type="checkbox"/> Pain into the Buttock | <input type="checkbox"/> <i>Trouble Swallowing</i> |
| <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Irritability | <input type="checkbox"/> Painful Joints | <input type="checkbox"/> Trouble Twisting |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cool Hands | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Pins and Needles in Arms/Hands | <input type="checkbox"/> Upper Back Pain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Knots in the Back Muscle | <input type="checkbox"/> Pins and Needles in Back/Legs/Feet | <input type="checkbox"/> <i>Upper Respiratory Infection</i> |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Light Bother Eyes | <input type="checkbox"/> <i>Polycystic Kidney Disease</i> | <input type="checkbox"/> <i>Urinary Tract Infections</i> |
| <input type="checkbox"/> <i>Dizziness</i> | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Postmenopausal | <input type="checkbox"/> <i>Vision problems</i> |
| <input type="checkbox"/> Drop Attack | <input type="checkbox"/> Lower Mid Back Pain | <input type="checkbox"/> Ringing in Ears | |
| | | <input type="checkbox"/> Sciatic Pain | |

Personal history of:(circle all that apply)

Anemia, Arthritis, Arteriosclerosis (hardening/thickening of artery walls), Asthma, Cancer: _____,
Cardiovascular Problems (Circulation issues, Swelling, etc), Congestive Heart Failure, COPD, COVID, Crohn's,
Depression, Diabetes, Dizziness/Fainting, Headaches, Heart Disease, Heart Attack, Heart Problems, Hepatitis, HIV,
High Blood Pressure, Hypertension, Irritable Bowel Syndrome, Kidney Problems, Liver Disease, Low Blood Pressure,
Osteoporosis, Pacemaker, Respiratory Problems, Rheumatoid Arthritis, Seizures, Stroke, Systemic Disease,
Tuberculosis, Thyroid Problems, Other: _____

*Have you received the COVID19 Vaccine? ___ No ___ Yes. Have you had the COVID virus? ___ No ___ Yes
(This question MUST be answered for our records)

Have you ever experienced in your lifetime any of the following: (circle all that apply)

Back Problems Sciatica Disc Disease Neck Problems Headaches None

In the past (at any time in your lifetime) have you had any: (circle all that apply)

Car Accidents Falls Work Injuries Sports Injuries None

Family History:

Has your mother had any of the above YES / NO, IF Yes, list conditions? _____

Is your mother deceased? YES / NO

Has your father had any of the above YES / NO, IF Yes, list conditions? _____

Is your father deceased? YES / NO

Has your grandparents, sister, brother had any of the above? YES / NO, IF Yes, list conditions? _____

Social History:

Do you drink alcohol? Yes / No If Yes, How Many? 1-2 3-4 5+ How Often? Daily Weekly Monthly Occasional/Social

Do you (circle one) smoke/vape tobacco? Never Former smoker Occasional/social (Light) Current (Daily) Smokeless tobacco

Do you (circle one) smoke / vape: Marijuana THC CBD Other: _____

Do you use (circle): THC / CBD products

Have you used illegal drugs? Yes / No

Do you exercise? YES / No, If Yes Circle one: Daily Weekly Monthly

If Yes, What Kind? Yoga/Pilates Weight Training Running/Jogging Other: _____

Primary Condition?

Duration of Condition?

Have you had the problem previously? YES NO

What previous treatment have you had?

What are you doing for it now?

What have you found to be effective?

Are you seeing another doctor for any reason, Including pregnancy? YES NO

If Yes, please explain:

What medications are you currently taking? (if not already provided)



Madison Heights Chiropractic Center

General Pain Index Questionnaire

Please mark how much your pain presently **prevents** you from doing what you would normally do. Regarding each category, please indicate the **overall** impact your present pain has on your life, not just when the pain is at its worst. Please **circle the number** which best describes how your typical level of pain affects these six categories of activities.

1. **Family at home responsibilities:** such as yard work, chores around the house or driving the kids to school

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

2. **Recreation:** including hobbies, sports or other leisure activities

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

3. **Social activities:** including parties, theater, concerts, dining out and attending other social functions

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

4. **Employment:** including volunteer work and homemaking tasks

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

5. **Self-care:** such as taking a shower, driving or getting dressed

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

6. **Life-support activities:** such as eating and sleeping

0 1 2 3 4 5 6 7 8 9 10

Completely able to function

Totally unable to function

Patient name: _____ Patient #: _____

Signature: _____ Date: _____