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 actually 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_____

Date of Birth_____ Age_____
(month) (day) (year)

Single _____ Married _____ 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, 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?_____

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 DIFFICULTY WITH 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)

( ) Acid Reflux/Heartburn
( ) Allergies
( ) Arthritis
( ) Asthma
( ) Base of Neck Pain
( ) Bladder Troubles
( ) Breast Implants
( ) Bulging Disc
( ) Bypass Surgery
( ) Cancer
( ) Chest Pain
( ) Clicking or Grinding in Neck
( ) Cluster Headaches
( ) Cold Feet
( ) Constipation
( ) Cool Hands
( ) Depression
( ) Diarrhea
( ) Dizziness
( ) Ear Infections
( ) Fatigue
( ) Frequent Urination
( ) Gall Bladder Trouble
( ) Head Feels Heavy
( ) Headaches
( ) Heart Attack
( ) Heart Problems
( ) Heart Trouble
( ) Herniated Disc
( ) Hip Pain
( ) Indigestion
( ) Inner Tension
( ) Intestinal Gas
( ) Irritability
( ) Jaw Pain
( ) Kidney Trouble
( ) Knots in the Back Muscle
( ) Light Bother Eyes
( ) Loss of Balance
( ) Low Back Pain
( ) Lower Mid Back Pain
( ) Menstrual Cramps and Pain
( ) Menstrual irregularity
( ) Mid Back Pain
( ) Mid Back Pain when Sleeping
( ) Migraines
( ) Muscle Spasms in Mid/Low Back
( ) Muscle Spasms in Neck
( ) Neck Pain
( ) Numbness of Arm or Hand
( ) Pain in Shoulder Blades
( ) Pain into feet
( ) Pain into Legs
( ) Pain into the Buttock
( ) Painful Joints
( ) Pinched Nerve
( ) Pins and Needles in Arms or Back
( ) Poor Circulation
( ) Postmenopausal
( ) Ringing in Ears
( ) Sciatic Pain
( ) Sexural Dysfunction
( ) Shooting Head Pain
( ) Shoulder Pain
( ) Shoulder Tightness
( ) Sinus Trouble
( ) Snoring
( ) Stiff Mid Back
( ) Stiff Neck
( ) Stomach Disorder
( ) Strokes
( ) Swollen Joints
( ) Throbbing Head Pain
( ) Thyroid Trouble
( ) Tingling in Fingers
( ) Trouble Bending
( ) Trouble Sleeping
( ) Trouble Twisting
( ) Ulcers
( ) Upper Back Pain
( ) Vascular Disease

Personal history of:
Stroke, Osteoporosis, Diabetes, Cancer: _____, Heart Disease, HBP, Arterial Scler, Other: _____

Family History:
Has your mother, father, grandparents, sister, brother had any of the above? YES / NO , What? _____
_____

Social History:
Do you drink alcohol? Yes / No Do you smoke? Never Former smoker Occasional/social Current
Have you used illegal drugs? Yes / No Have you ever been treated for substance abuse? YES / NO

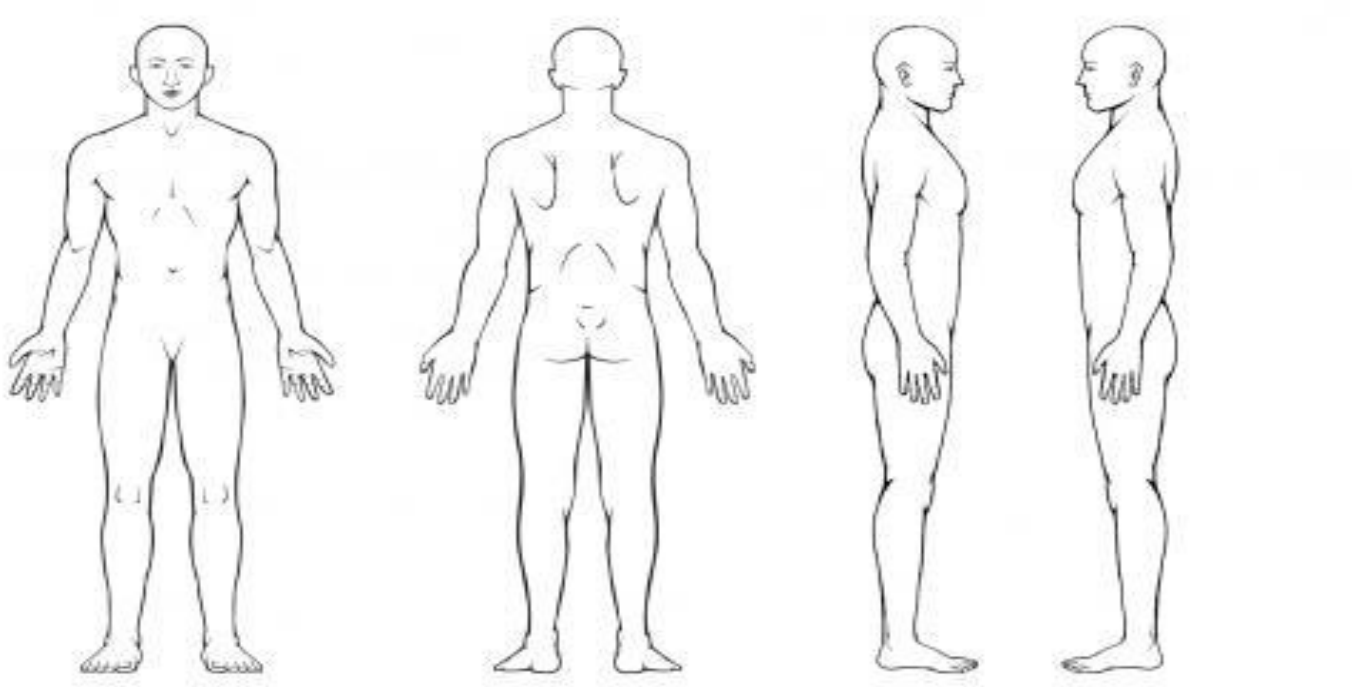
Have you ever experienced:
Back Problems, Sciatica, Disc Disease, Neck Problems, Headaches in your lifetime? YES / NO

In the past (at any time in your lifetime) have you had any:
Car Accidents, Falls, Work Injuries, Sports Injuries? YES / NO

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)

Use the letters below to indicate the type of pain and location(s):

A= **Ache**
B= **Burning**
N= **Numbness**
P= **Pins and Needles/Tingling**
S= **Stabbing**
0= **Other**



I certify that the given information is true and complete to the best of my knowledge:

Patient's Signature: _____
(Parent if patient is a minor)

_____

Official Use Only:

Additional Comments:

_____
_____
_____
_____
_____
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_____

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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: _____