

Ann Arbor Chiropractic Wellness Center Case History

Date: _____

Patient Information

Name: _____ Phone: _____ cell home work
Address: _____ City: _____ State: ____ Zip: _____
E-Mail: _____ Sex: M F Birth date: _____ Age: ____
 Married Widowed Single Minor Separated Divorced Partnered for ____ years
Occupation: _____ Employer: _____ Phone: _____
Spouse's Name: _____ Birth date: _____ Number of children: _____
Children's ages: _____ Are you pregnant? Yes No
Who referred you to our office? _____

Patient Condition

Reason for visit: _____

When did your symptom(s) appear? _____

Have you ever had the same or a similar condition? Yes No

If yes, when and describe: _____

Is this condition getting progressively worse? Yes No

Please mark an X on the picture where you are experiencing the symptom(s)

Type of pain: Sharp Burning Dull Throbbing Numb Achy
 Tingling Cramps Stiff Swelling Other

How often do you have this symptom? _____

Is the symptom constant or does it come and go? Constant Comes and goes

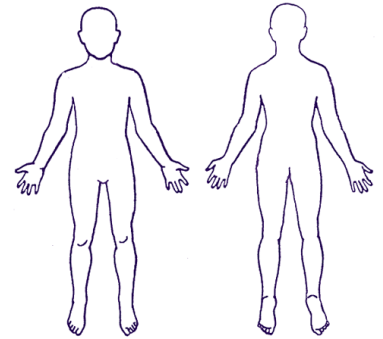
Check the activities your symptom interferes with: Work Sleep Daily routine

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying down

Have you lost any days from work? Yes No If yes, how many? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? (Women, please include information about childbirth) Yes No

If yes, please describe: _____



Accident Information

Is this condition due to an accident? Yes No (If yes, please notify the front desk for additional paperwork)

(Continue on back)

Insurance

What insurance provider will you be using? _____ Contract number: _____

Subscriber's name: _____ Subscriber's birth date: _____

Relationship to subscriber: _____

Assignment and Release: I certify that I, and/or my dependent(s) have insurance coverage under this policy and I agree to assign this insurance company to pay Dr. Michael Meath at Ann Arbor Chiropractic Wellness Center all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance policy. I authorize the use of my signature on all insurance submissions.

Dr. Michael Meath may use my health care information and may disclose such information to the above insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Please your name or guardian of patient's name: _____

Signature of patient or guardian of patient: _____ Date: _____

Health History

What treatment have you already received for your condition? Medication(s) Surgery Physical Therapy
 Chiropractic None Other _____

Name of doctor and clinic who have treated you for your condition: _____

Date of last: Physical exam _____ Spinal X-Ray _____ Blood Test _____

Spinal exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone scan _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter N if you have these conditions now or P if you have previously had these conditions.

	N= Now	P=Previously
Headaches _____	Frequency _____	Loss of Balance _____
Neck Pain _____		Fainting _____
Stiff Neck _____		Loss of Smell _____
Sleeping Problems _____		Loss of Taste _____
Back Pain _____		Unusual Bowel Patterns _____
Nervousness _____		Cold Feet _____
Tension _____		Cold Hands _____
Irritability _____		Arthritis _____
Chest Pains/Tightness _____		Muscle Spasms _____
Dizziness _____		Frequent Colds _____
Shoulder/Neck/Arm Pain _____		Fever _____
Numbness in Fingers _____		Sinus Problems _____
Numbness in Toes _____		Diabetes _____
High Blood Pressure _____		Indigestion Problems _____
Difficulty Urinating _____		Joint Pain/Swelling _____
Weakness in Extremities _____		Menstrual Difficulties _____
Breathing Problems _____		Weight Gain/Loss _____

(Continue on next page)

Fatigue	___	Depression	___
Lights bother eyes	___	Loss of Memory	___
Ears Ring	___	Buzzing in Ears	___
Broken Bones/Fractures	___	Circulation Problems	___
Rheumatoid Arthritis	___	Seizures/Epilepsy	___
Excessive Bleeding	___	Low Blood Pressure	___
Osteoarthritis	___	Osteoporosis	___
Pacemaker	___	Heart Disease	___
Stroke	___	Cancer	___
Ruptures	___	Coughing Blood	___
Eating Disorder	___	Alcoholism	___
Drug Addiction	___	HIV Positive	___
Gall Bladder Problems	___	Depression	___
Ulcers	___		

Social History

Please indicate beside each activity whether you engage in it:

O=Often S=Sometimes N=Never

Vigorous Exercise	___	Family Pressures	___	Moderate Exercise	___
Financial Pressures	___	Alcohol Use	___	Other Mental Stresses	___
Drug Use	___	Tobacco Use	___	Caffeine	___
High Stress Activity	___	Other (please specify)	_____		

Family History

Please review the below listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, so some hereditary conditions are affected by similar climate.

Condition	Father Age:	Mother Age:	Spouse Age:	Brother Age:	Sister Age:	Children Age:
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						

(Continue on back)

Condition	Father Age:	Mother Age:	Spouse Age:	Brother Age:	Sister Age:	Children Age:
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraines						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other						

If any of the above family members are deceased, please list their name, age at death, and cause.

1. _____
2. _____
3. _____
4. _____
5. _____