Dr. Michael J. Meath
2730 Carpenter Rd. Suite 3

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? _____

Insurance

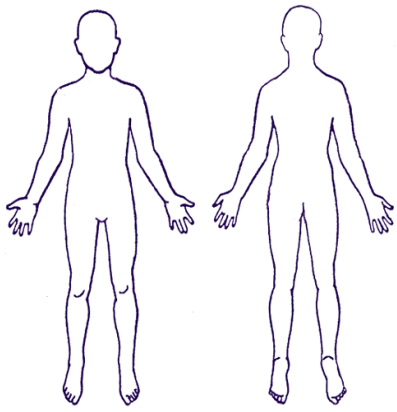
Is this condition due to an accident? ☐ Yes ☐ No (If yes, please notify the front desk for additional paperwork)
What insurance provider will you be using? _____ Contract number: _____
Subscriber's name: _____ Subscriber's birth date: _____
Relationship to subscriber: _____
Assignment and Release: I 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 print your name or guardian of patient's name: _____
Signature of patient or guardian of patient: _____ Date: _____

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: _____

(Continue on back)

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	____
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	____		

(Continue on next page)

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						
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. _____

(Continue on back)