PREFERRED CHIROPRACTIC OF MIDLAND

Preferred Chiropractic of Midland

214 W Wackerly St Suite 100 Midland, Ml 48640

Patient Information Form

Please complete this form and email to chiromidland@gmail.com. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe that your condition will respond satisfactorily, we will not accept your case. Thank You.

General Information

Last Name _____ First Name _____ Middle Initial _____

Address _____City _____ State _____ Zip _____

Home Phone (____)_____ E-mail Address _____

What do you prefer to be called?_____ **How were you referred to us?** _____

Employer/Occupation _____ Hours you usually work:_____to_____ Okay to call work? ☐**Y** ☐**N**

Sex:☐M ☐F Birth Date: ____/____/_____ Age: _____ Social Security Number _____-_____-_____

Marital Status:☐M ☐S ☐W ☐D Spouse's Name _____ Spouse's DOB____/__/_____

Have you ever seen a Chiropractor Before?☐**Y** ☐**N** If Yes, Who and When? _____

Why do you brush your teeth? _____

Health Information

Is your condition the result of an Auto Accident? ☐**Y** ☐**N** Is your condition the result of a work related injury?☐**Y** ☐**N**

Have you EVER been in ANY KIND of Auto Accident? ☐**Y** ☐**N If Yes, When?** ☐**Past year** ☐**Past 5 yrs** ☐**Over 5 yrs**

Describe:_____

What is your major complaint? _____ Other complaints? _____

What areas of your life have been affected by your pain and symptoms? _____

_____

What activities are aggravated by your condition? _____

Is your condition: Getting progressively worse?☐**Y** ☐**N** Constant?☐**Y** ☐**N** Does it Come and Go?☐**Y** ☐**N**

Is your condition interfering with: Work?☐**Y** ☐**N** Sleep?☐**Y** ☐**N** Daily Routine?☐**Y** ☐**N** Other _____

How long has it been since you felt good?_____ Have any other Doctors treated you for this condition?☐**Y** ☐**N**

If Yes, Who and When? _____

List all surgical operations and years_____

Drugs you are taking:☐Nerve Pills ☐Pain Killers ☐Muscle Relaxers ☐Tranquilizers ☐Anti-Depressants ☐Birth Control ☐Others _____ How old is your mattress? _____ Is it comfortable?☐**Y** ☐**N**

Do you wear: Heel lifts?☐**Y** ☐**N** Sole lifts?☐**Y** ☐**N** Arch Supports?☐**Y** ☐**N** Other _____

For Women: Are you pregnant? ☐**Y** ☐**N** If Yes, how far along? _____ Are you nursing?☐**Y** ☐**N**

I guarantee that this form was completed correctly to the best of my knowledge. I authorize the doctors and/or staff at Preferred Chiropractic of Midland to perform any services necessary during my diagnosis and treatment. I understand that it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____

☐Adult Patient ☐Parent or Legal Guardian ☐Spouse

PREFERRED CHIROPRACTIC
OF MIDLAND

Patient Name: _____ Date _____

BP: _____/_____

PULSE: _____

HEIGHT: _____

WEIGHT: _____

Office Use

Cell Phone: _____

Other Phone: _____

Email Address: _____

Race (Circle One): ☐ White ☐ African American ☐ Hispanic/Latino ☐ American Indian

☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Other _____

Please list all medications with dosage that you are taking at this time:

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

Please list additional medications on the back of this form.

Primary Care Physician: _____

Physicians Phone Number: _____

Do you have any allergies to medications? ☐ **Y** ☐ **N** If yes, please list medication and reaction:

Circle any that apply: ☐ Nausea ☐ Vomiting ☐ Hives ☐ Headaches ☐ Fever

Other: _____

_____

Have you ever used tobacco? ☐ Past ☐ Present ☐ Never

What type? _____

If Cigarettes, how many packs a day? _____

If cigars, how many do you smoke per day? _____

If any other, how much? _____

Please email this completed form to chiromidland@gmail.com