Next Level Chiropractic & Wellness

625 N. State St., Ste. B · Caro, MI 48723 · (989) 208-3847

PATIENT INTAKE

Adult Intake & Health History

About the Patient

Name _____ Today's Date _____ Birthdate _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Gender ☐ M ☐ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

E-mail Address _____ Have you been to a chiropractor before? ☐ No ☐ Yes

Emergency Contact _____ Ph # _____

Name of Medical Doctor(s) _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Next Level Chiropractic & Wellness to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- **Person responsible for this account if other than the patient?** _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- **For my balance my preferred payment method is:** ☐ Cash ☐ Check ☐ Credit Card ☐ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) **Date**

Reason for Seeking Care

Present complaints

1 **Complaint** _____ **How long has this been an issue?** _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse

☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening **Pain radiates to** _____

2 **Complaint** _____ **How long has this been an issue?** _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse

☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening **Pain radiates to** _____

3 **Complaint** _____ **How long has this been an issue?** _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse

☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening **Pain radiates to** _____

4 **Complaint** _____ **How long has this been an issue?** _____

Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse

☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening **Pain radiates to** _____

5. Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving

6. What makes it better? _____

7. What makes it worse? _____

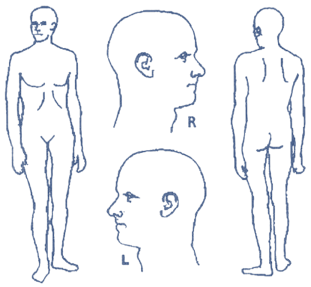
8. What Doctor's have you seen for this? _____

9. Type of treatment: _____

10. Results: _____

Notes: _____

Please mark all areas of concern.



Are you pregnant? ☐ Yes ☐ No

General Health History

Patient Name _____ Mark the conditions that apply to you.

PAST	PRESENT		PAST	PRESENT	
☐	☐	Headaches	☐	☐	Urinary Problems
☐	☐	Migraines	☐	☐	Easy Bruising
☐	☐	Shortness of Breath	☐	☐	Tobacco Use
☐	☐	Allergies / Asthma	☐	☐	Dental Problems
☐	☐	Medication Side Effects	☐	☐	Fibromyalgia
☐	☐	Diabetes	☐	☐	Blood Thinner use
☐	☐	Hands or Feet cold	☐	☐	HIV Positive
☐	☐	Muscle aches	☐	☐	Cancer
☐	☐	Trouble Walking	☐	☐	Depression
☐	☐	Leg / Foot Numbness	☐	☐	Alcohol Use
☐	☐	Fainting	☐	☐	___ High or ___ Low Blood Pressure
☐	☐	Gall Bladder Trouble	☐	☐	Stroke History
☐	☐	Ringing in Ears	☐	☐	High Cholesterol
☐	☐	Ear Problems	☐	☐	TMJ
☐	☐	Sleeping Problems	☐	☐	Digestive Problems
☐	☐	Vision Problems	☐	☐	Pain all Over
☐	☐	Thyroid Problems	☐	☐	Tension / Irritability
☐	☐	Liver Disease	☐	☐	Chest Pains
☐	☐	Kidney Problems	☐	☐	Heart Pacemaker
☐	☐	Light Bothers Eyes	☐	☐	Heart Problems

☐ ☐ Other _____

MEDICATIONS & DOCTORS

1. List any medications you are taking: _____

_____

2. Please list all doctors you are currently seeing: _____
3. Has any Doctor or other professional advised you to "Go to a Chiropractor"? ☐ No ☐ Yes, Name _____

_____

Past History

4. List any past auto collisions: _____ Was any care received? _____
5. List any past work injuries: _____ Was any care received? _____
6. List any past sport, recreational, or home injuries: _____
7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

Family History

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis Other _____

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis Other _____

Is there any other family history you want us to know? _____

_____