Reno Chiropractic Center - 11429 15 Mile Rd - Sterling Heights, MI 48312 - (586) 264-4700

Date _____

Name_____Age_____Birthdate_____
Address _____ City _____ State _____
ZIP Code _____Social Security # _____
Home Phone # _____Work #_____ Cell Phone #_____
E-Mail Address _____Marital status: M S D W
Name of wife or husband _____ Ages of children_____
Spouse's Employer _____Business Phone _____
Employer _____ Occupation _____
Referred to our office by _____

Please Mark all services you are interested in: □ Chiropractic □ Massage □PEMF □Foot Levelers

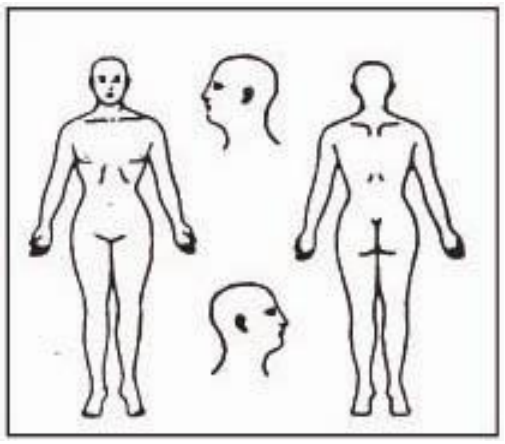
Please describe the principal health problems/concern for which you came to this office. _____
_____
How and when did symptoms first occur? _____
List any other doctors seen for these problems _____
List diagnosis(es) and type of treatment(s) _____
_____
Does this interfere with your normal living and work? Yes No In what way?_____
Have you lost any days of work? Yes No Dates _____
Have you had similar symptoms or injuries before? Yes No If yes, explain _____
_____

Who is responsible for your bill? Self/Spouse/Company/Insurance/Other _____
___ Self Pay ___Worker's Compensation ___ Health Insurance ___ Automobile Ins. Policy
Name of Insurance Co. _____
Subscriber's name_____ Subscriber's DOB_____
Subscriber's Relationship to Patient_____ Subscriber's Employer_____
Is there additional coverage?_____ If yes, Name_____
Subscriber's Name and DOB_____

PAST HISTORY

Has a physician treated you for any health condition in the last year? Yes No
If yes, explain: _____
_____
Have you or any relative received Chiropractic treatment previously? Yes No If yes, explain _____
_____
Have you ever had a massage before? Yes No
If yes, what type of pressure do you prefer: Light Moderate Deep
List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include any broken bones) _____
_____
List all drugs or medication that you have used recently (i.e., aspirin, sleeping pills, birth control pills, etc.)
_____
_____
List all supplements that you are currently taking _____
_____
Do you exercise? Yes No, If yes, what type and how often. _____
_____

Please mark your areas of pain on the figures below.



List the conditions that you are most interested in getting corrected. List in order of importance:

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

What functions are you unable to perform or induce pain upon performance?
List in order of severity. (Example: sitting, walking, bending, lying down, etc.)

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

If you have ever had a listed symptom in the past, please check that symptom in the Past Column. If you are presently having a particular symptom, check that symptom in the Present column. **CORRECTLY ANSWERING THE CONDITIONS CAN INFLUENCE TREATMENT CHOICES AND OUTCOME OF CARE.**

Past	Present	Condition
☐	☐	Abdominal Pain
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Anemia
☐	☐	Anorexia
☐	☐	Aortic Aneurysm
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Bladder Infection
☐	☐	Blood Disorder
☐	☐	Breast: Soreness Lumps
☐	☐	Cancer, Explain_____
☐	☐	Chest Pains
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	Cold Hands, Feet
☐	☐	Colitis
☐	☐	Constipation/irregular bowel habits
☐	☐	Convulsions
☐	☐	Diabetes
☐	☐	Depression
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Difficulty in Swallowing
☐	☐	Dizziness
☐	☐	Emphysema/Chronic lung disorder
☐	☐	Endometriosis
☐	☐	Epilepsy
☐	☐	Excessive Thirst

Past	Present	Condition
☐	☐	Fainting
☐	☐	Frequent Urination
☐	☐	General Fatigue
☐	☐	Hand Pain (R_____ L_____)
☐	☐	Headache _____
☐	☐	Heart Attack (date)
☐	☐	Heartburn/Indigestion
☐	☐	High / Low Blood Pressure
☐	☐	Irregular Menstrual Flow
☐	☐	Irritable Colon
☐	☐	Jaw Pain
☐	☐	Kidney Issues
☐	☐	Liver/Gallbladder problems
☐	☐	Loss of Appetite
☐	☐	Loss of Balance
☐	☐	Loss of Bladder Control
☐	☐	Low Back Pain
☐	☐	Menstrual Cramps, Pain
☐	☐	Mid Back Pain
☐	☐	Muscular In-coordination
☐	☐	Neck Pain
☐	☐	Numbness _____
☐	☐	Pain in Ankle or Foot
☐	☐	Pain in Lower Leg or Knee
☐	☐	Pain in Upper Arm, Elbow, Wrist
☐	☐	Pain in Upper Leg or Hip
☐	☐	Painful Urination

Past	Present	Condition
☐	☐	PMS
☐	☐	Prostate Problems
☐	☐	Rapid Heart Beat
☐	☐	Rheumatoid Arthritis
☐	☐	Scoliosis
☐	☐	Shoulder Pain
☐	☐	Spinal Subluxation
☐	☐	Stroke (Date)_____
☐	☐	Swelling, Stiffness of Joint(s)_____
☐	☐	Tinnitus (Ear Noises)
☐	☐	Thyroid Issues
☐	☐	Ulcer
☐	☐	Visual Disturbances
☐	☐	Other_____

Have You or Your Family Had:

Yes	No	
☐	☐	Cancer
☐	☐	Rheumatoid Arthritis
☐	☐	Epilepsy
☐	☐	Diabetes
☐	☐	Chronic Back Problems
☐	☐	Heart Problems
☐	☐	Chronic Headaches
☐	☐	Lung Problems
☐	☐	High Blood Pressure
☐	☐	Lupus

Present Weight _____Pounds Height _____Feet _____Inches

Please check any of the following that apply to you

Past	Present		Past	Present	
☐	☐	Pregnancy,# births_____	☐	☐	Tobacco___ packs/day
☐	☐	Birth control pills, Type_____	☐	☐	Alcohol __drinks/day/week/month
☐	☐	Coffee/Tea/Caffeinated Soft drinks	☐	☐	Drug or Alcohol Dependence
☐	☐	_____cups/cans per day			