

# Bristol Chiropractic Centre, P.C.

5098 West Bristol Road, Flint, MI 48507

## Outline Procedures For New Patients

- Step One:** All new patients are requested to fill out a personal health questionnaire prior to their appointment.
- Step Two:** Your consultation with a doctor to discuss your health problems.
- Step Three:** Diagnostic: Chiropractic, Orthopedic, and Neurological examination procedures to determine if chiropractic care is appropriate for your condition.
- Step Four:** You will be advised if there is a need for any additional procedures such as x-rays, MRI, & CAT scan.
- Step Five:** If your case requires immediate attention, treatment will be administered.
- Step Six:** Upon completion of today's tests and exam procedures, you will be scheduled for a "Report of Findings" so that the doctor will inform you as to your examination results and whether or not your case has been accepted. At that time you will be informed of specific recommendations in regards to your condition.
- Step Seven:** If appropriate, your treatment plan will begin following your "Report of Findings".

## Confidential Patient Information

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date: \_\_\_\_\_  
Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Marital: M S W D How Many Children? \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Referred By: Patient (Name) \_\_\_\_\_ Physician (Name) \_\_\_\_\_  
Therapist (Name) \_\_\_\_\_ Ad (Location) \_\_\_\_\_  
Is your condition due to injury or sickness arising out of patient's employment? Y\_\_N\_\_ Date of accident: \_\_\_\_\_  
Date of last physical examination: \_\_\_\_\_ Female: Are you pregnant? Y\_\_\_\_N\_\_\_\_  
What operations have you had: \_\_\_\_\_  
Serious Illnesses: \_\_\_\_\_ Fractured Bones: \_\_\_\_\_  
Have you ever been under chiropractic care: Y\_\_\_\_N\_\_\_\_ Doctor's Name: \_\_\_\_\_  
In case of emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Work Status: Employed\_\_\_\_ Retired\_\_\_\_ Disabled\_\_\_\_ Full-Time Student\_\_\_\_ Part-Time Student\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ Policy Holder's D.O.B.: \_\_\_\_\_  
Contract #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Name of Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name of Spouse/ Partner: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_

## Why Chiropractic ?

People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved to avoid future relapses (**Corrective Care**). Still others want what is malfunctioning in their bodies brought to the highest state of health possible in order to optimize their physical and emotional well-being (**Comprehensive Care**). Chiropractic Neurology offers some of the latest advanced procedures for optimizing your nervous system function. Bristol Chiropractic Centre, P.C. stresses that it is always YOUR CHOICE to choose which care you desire. We will honor and support your choice and your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care you wish to receive.

**Relief Care**\_\_ **Corrective Care**\_\_ **Comprehensive Care**\_\_ **I would like to discuss my options with the doctor** \_\_

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## Complaint# 1

When did you first notice this condition? \_\_\_\_\_

Did it begin: **Immediate** \_\_\_ or **Gradually**? \_\_\_ (Please Describe Briefly) \_\_\_\_\_

What is the exact location of your symptoms? \_\_\_\_\_

Do your symptoms radiate? If Yes where? \_\_\_\_\_

How often are you experiencing these symptoms? **Constantly** \_\_\_ **Frequent (75%)** \_\_\_ **Often (50%)** \_\_\_ **Rarely(25%)** \_\_\_

Is this condition: **Worsening** \_\_\_ **Improving** \_\_\_ **Remaining Unchanged** \_\_\_

What is the intensity of your symptoms? **Severe** \_\_\_ **Mild** \_\_\_ **Moderate** \_\_\_

Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating) \_\_\_\_\_

Is your pain **superficial** \_\_\_ or **deep** \_\_\_

Please indicate the character of your pain: **Dull** \_\_\_ **Sharp** \_\_\_ **Burning** \_\_\_ **Aching** \_\_\_ **Knife-Life** \_\_\_ **Throbbing** \_\_\_

Are you experiencing any of the following associated symptoms? **Pins & Needles** \_\_\_ **Tingling** \_\_\_ **Numbness** \_\_\_

**Twitching of muscles** \_\_\_ If yes, please describe \_\_\_\_\_

Please indicate what activities **Provoke (P) or Aggravate (A)** your condition:

Sitting \_\_\_ Standing \_\_\_ Walking \_\_\_ Lying \_\_\_ Lifting \_\_\_ Pushing \_\_\_ Pulling \_\_\_ Gripping \_\_\_ Hot/Cold \_\_\_

Coughing/ Sneezing \_\_\_ Mental Activities \_\_\_ Bright Lights \_\_\_ Other \_\_\_\_\_ Other \_\_\_\_\_

Please indicate what helps you to relieve the pain:

Sitting \_\_\_ Standing \_\_\_ Walking \_\_\_ Lying \_\_\_ Heat/Cold \_\_\_ Rest \_\_\_ Medications \_\_\_ Other \_\_\_\_\_

\*\*\*\*\* Please DO NOT write below this line \*\*\*\*\*

## Complaint# 2

When did you first notice this condition? \_\_\_\_\_

Did it begin: **Immediate** \_\_\_ or **Gradually**? \_\_\_ (Please Describe Briefly) \_\_\_\_\_

What is the exact location of your symptoms? \_\_\_\_\_

Do your symptoms radiate? If Yes where? \_\_\_\_\_

How often are you experiencing these symptoms? **Constantly** \_\_\_ **Frequent (75%)** \_\_\_ **Often (50%)** \_\_\_ **Rarely(25%)** \_\_\_

Is this condition: **Worsening** \_\_\_ **Improving** \_\_\_ **Remaining Unchanged** \_\_\_

What is the intensity of your symptoms? **Severe** \_\_\_ **Mild** \_\_\_ **Moderate** \_\_\_

Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating) \_\_\_\_\_

Is your pain **superficial** \_\_\_ or **deep** \_\_\_

Please indicate the character of your pain: **Dull** \_\_\_ **Sharp** \_\_\_ **Burning** \_\_\_ **Aching** \_\_\_ **Knife-Life** \_\_\_ **Throbbing** \_\_\_

Are you experiencing any of the following associated symptoms? **Pins & Needles** \_\_\_ **Tingling** \_\_\_ **Numbness** \_\_\_

**Twitching of muscles** \_\_\_ If yes, please describe \_\_\_\_\_

Please indicate what activities **Provoke (P) or Aggravate (A)** your condition:

Sitting \_\_\_ Standing \_\_\_ Walking \_\_\_ Lying \_\_\_ Lifting \_\_\_ Pushing \_\_\_ Pulling \_\_\_ Gripping \_\_\_ Hot/Cold \_\_\_

Coughing/ Sneezing \_\_\_ Mental Activities \_\_\_ Bright Lights \_\_\_ Other \_\_\_\_\_ Other \_\_\_\_\_

Please indicate what helps you to relieve the pain:

Sitting \_\_\_ Standing \_\_\_ Walking \_\_\_ Lying \_\_\_ Heat/Cold \_\_\_ Rest \_\_\_ Medications \_\_\_ Other \_\_\_\_\_

\*\*\*\*\* Please DO NOT write below this line \*\*\*\*\*

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## Complaint# 3

When did you first notice this condition? \_\_\_\_\_

Did it begin: **Immediate** \_\_\_ or **Gradually**? \_\_\_ (Please Describe Briefly) \_\_\_\_\_

What is the exact location of your symptoms? \_\_\_\_\_

Do your symptoms radiate? If Yes where? \_\_\_\_\_

How often are you experiencing these symptoms? **Constantly** \_\_\_ **Frequent (75%)** \_\_\_ **Often (50%)** \_\_\_ **Rarely(25%)** \_\_\_

Is this condition: **Worsening** \_\_\_ **Improving** \_\_\_ **Remaining Unchanged** \_\_\_

What is the intensity of your symptoms? **Severe** \_\_\_ **Mild** \_\_\_ **Moderate** \_\_\_

Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe/excruciating) \_\_\_\_\_

Is your pain **superficial** \_\_\_ or **deep** \_\_\_

Please indicate the character of your pain: **Dull** \_\_\_ **Sharp** \_\_\_ **Burning** \_\_\_ **Aching** \_\_\_ **Knife-Life** \_\_\_ **Throbbing** \_\_\_

Are you experiencing any of the following associated symptoms? **Pins & Needles** \_\_\_ **Tingling** \_\_\_ **Numbness** \_\_\_

**Twitching of muscles** \_\_\_ If yes, please describe \_\_\_\_\_

Please indicate what activities **Provoke (P) or Aggravate (A)** your condition:

Sitting \_\_\_ Standing \_\_\_ Walking \_\_\_ Lying \_\_\_ Lifting \_\_\_ Pushing \_\_\_ Pulling \_\_\_ Gripping \_\_\_ Hot/Cold \_\_\_

Coughing/ Sneezing \_\_\_ Mental Activities \_\_\_ Bright Lights \_\_\_ Other \_\_\_\_\_ Other \_\_\_\_\_

Please indicate what helps you to relieve the pain:

Sitting \_\_\_ Standing \_\_\_ Walking \_\_\_ Lying \_\_\_ Heat/Cold \_\_\_ Rest \_\_\_ Medications \_\_\_ Other \_\_\_\_\_

\*\*\*\*\* Please DO NOT write below this line\*\*\*\*\*

## Confidential Patient Information Cont.

**HAVE YOU EVER SUFFERED FROM THE FOLLOWING: PLEASE CHECK ALL THAT APPLY.**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Allergy             | <input type="checkbox"/> Nervous Depression   | <input type="checkbox"/> Sinus Infection  | <input type="checkbox"/> Bed-Wetting            |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Colon Trouble        | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Frequent Urination     |
| <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Diarrhea             | <input type="checkbox"/> Colds            | <input type="checkbox"/> Kidney Infection/Stone |
| <input type="checkbox"/> Headache            | <input type="checkbox"/> Difficulty Digestion | <input type="checkbox"/> Deafness         | <input type="checkbox"/> Prostate Trouble       |
| <input type="checkbox"/> Loss of Sleep       | <input type="checkbox"/> Hemorrhoids          | <input type="checkbox"/> Ear Noises       | <input type="checkbox"/> Cramps or Backache     |
| <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Nausea               | <input type="checkbox"/> Enlarged Thyroid | <input type="checkbox"/> Excessive Menses       |
| <input type="checkbox"/> Numbness            | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Eye Pain         | <input type="checkbox"/> Hot Flashes            |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Low Blood Pressure   | <input type="checkbox"/> Failing Vision   | <input type="checkbox"/> Irregular Cycle        |
| <input type="checkbox"/> Bursitis            | <input type="checkbox"/> Pain Over Heart      | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Lumps in Breast        |
| <input type="checkbox"/> Foot Trouble        | <input type="checkbox"/> Poor Circulation     | <input type="checkbox"/> Bruise Easily    | <input type="checkbox"/> Alcoholism             |
| <input type="checkbox"/> Low Back Pain       | <input type="checkbox"/> Rapid Heart Beat     | <input type="checkbox"/> Hay Fever        | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Sciatica            | <input type="checkbox"/> Slow Heart Beat      | <input type="checkbox"/> Nose Bleeds      | <input type="checkbox"/> Glaucoma               |
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Cancer           | <input type="checkbox"/> Autoimmune Disease     |
| <input type="checkbox"/> Poor Posture        | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Pleurisy         | <input type="checkbox"/> Mental Disorders       |
| <input type="checkbox"/> Spinal Curvatures   | <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Spitting         | <input type="checkbox"/> Balance/Coordination   |
| <input type="checkbox"/> Swollen Joints      | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Itching          | <input type="checkbox"/> Epilepsy               |
| <input type="checkbox"/> Venereal Disease    | <input type="checkbox"/> Swelling of Ankles   | <input type="checkbox"/> Varicose Veins   | <input type="checkbox"/> Polio                  |

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## Confidential Patient Information Cont.

**Family History:** Have any of your family members ever suffered from the following conditions?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Depression/ Mental Illness |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Autoimmune Disorders   | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Other _____                |

**Medications:** Please list your current medications and what they are taken for \_\_\_\_\_

**Vitamins and Minerals:** Do you take any vitamins/minerals? YES \_\_\_ NO \_\_\_

If your answer is NO do you think you may need them? YES \_\_\_ NO \_\_\_

Are you currently wearing or have ever worn: **Inner Soles:** YES \_\_\_ NO \_\_\_ **Heel Lifts:** YES \_\_\_ NO \_\_\_

**Sole Lifts:** YES \_\_\_ NO \_\_\_ **Arch Supports:** YES \_\_\_ NO \_\_\_

<b>Habits:</b>	Heavy	Moderate	Light	None		Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

**Family Doctor** \_\_\_\_\_ **Address** \_\_\_\_\_

**Family Doctor's Phone & Fax #** \_\_\_\_\_

Would you like us to send a report? Yes \_\_\_ No \_\_\_

**Payment is expected at time of service.**

Name of person responsible for payment \_\_\_\_\_

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Bristol Chiropractic Centre, P.C. will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Bristol Chiropractic Centre, P.C. will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.*

I will be paying today by: **Cash** \_\_\_ **Check** \_\_\_ **Credit Card** \_\_\_

Card Name & #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's Signature Authorizing Care: \_\_\_\_\_ Date: \_\_\_\_\_

Information Taken By: \_\_\_\_\_ Date: \_\_\_\_\_

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