Welcome to Grosse Ile Family Chiropractic!

New Patient History

Date of Initial Visit ________________________

Name (Please Print)____ Date of birth__________________ Age_________

Address____ City_________________ State ___ Zip__________

Phone ________________________ Cell Phone _____________________ Marital status: S _____M ____ # of Children _____

Occupation____ Employer_________________________________

Primary Insurance Plan____ Patient ID #_______________________________

Secondary Insurance ____ Secondary ID#_____________________________

Spouse's name____ Date of Birth ______________________________

Referred by____ Primary MD ______________________________

***Kindly circle your level of pain*:** **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Possible)**

Please explain your reason for coming into chiropractic care today:

Major area of concern____

____

Pain/Problem started on_____________________ Check the type of pain you are feeling:

Sharp _____ Dull Ache _____ Constant _____Intermittent _____Other ______

Does this pain shoot, radiate, or travel in your body?__________ Where?_____________

Are you experiencing numbness or tingling anywhere? ________ Where? _____________

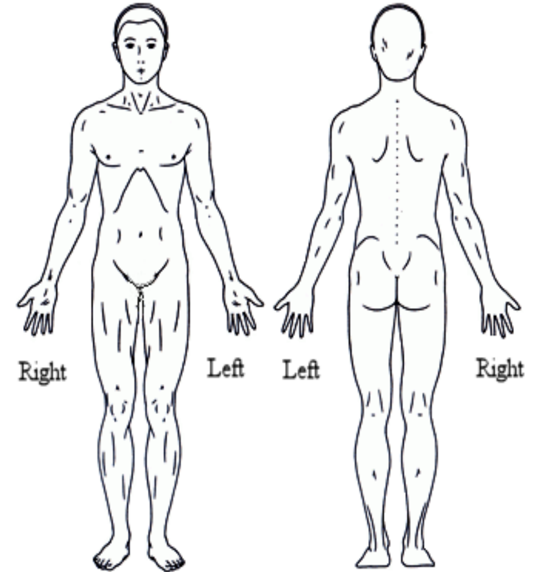
Since it began, is it: Same _____ Better _____Worse at certain times _______

What activities aggravate your condition? ____________________________________

Is the pain interfering with work______ sleep ______activities of daily living ________

What other doctors have you seen for this condition___________ Diagnosis? _________

Please mark areas of discomfort below:



Are you under medical care for any condition at this time? _______ How long? ________ Have they taken X-rays_________ MRI ________

CT Scan _______ Are you able to obtain a copy for this office? _____ Location where they were taken? ________________________

Have you had any spinal surgery? ____ When ____________ What level? ____ Neck (C/S) ____ Mid Back (T/S) ____ Low Back (L/S) ____

What side effects have you experienced from the drugs and surgery? ____

***Medications/ Vitamins*:** List any vitamins or medications are you now taking? ____

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____

Early Childhood: Describe any challenges that you may know of? ____
Ear infections/colic/asthma ___________Attention Deficit ___________ Antibiotics ___________ Broken bones _______________________
Any traumas? _____________________ Car accidents ______________ Chair pulled from under you________________________________

Current Health Habits: Did/do you smoke? ____ Drink alcohol? ____Do you eat healthy foods? ____ Do you exercise regularly? ________
Do you have dental/eye/hearing problems? _____ Did/do you have occupational stress?________ Physical/ emotional/mental stress? ________
Do you sleep well______________ Hours of sleep/ night____ Sleeping posture: Side ____ Stomach ____ Back ____ Arms over head _______

In your adult life have you ever been in a car accident of fallen?_______ Please explain ____

Please mark any of the following conditions or symptoms that you have now or have experienced:

O Headaches	O Pain in Hands or Arms	O Chest Pains	O Loss of Balance
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack	O Ringing in Ears
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure	O Jaw/TMJ Problems
O Low Back Pain	O Numbness in Legs or Feet	O Stroke	O Menstrual Cramps
O Nervousness	O Fatigue	O Cancer	O Menopause
O Tension	O Depression	O Painful Urination	O Cold Hands
O Irritability	O Lights Bother Eyes	O Diabetes	O Cold Feet
O Dizziness	O Loss of Memory	O Diarrhea	O Weight Loss
O Pain Between Shoulders	O Shoulder Pain	O Constipation	O Loss of Smell or Taste
O Stiff Neck	O Sinus	O Stomach Upset	O Fever
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux	O Asthma O Allergies

Please list any other conditions diagnosed by your medical doctors in the past or present that you would like us also to include:

____

____

Mark with an "X" any condition listed below that has affected your family history:

	Heart disease	Lung disease	Arthritis	Cancer	Diabetes	___________
Father's side	O	O	O	O	O	O
Mother's side	O	O	O	O	O	O

***Please sign below**: I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge. I do understand that it is my responsibility to inform this office of any changes in my health, as they occur. I agree to allow the doctor to examine me for further evaluation and acceptability into chiropractic care. In addition, when necessary, permission is granted to the doctor to discuss my care with* ________________________________

Emergency Contact ___________________________ Phone________________ Relationship to Patient _______________

Patient Signature_____________________________ Date ___________ E-Mail __________________________________

Doctor's Notes ____

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Doctor's Signature ____Roberta R Synowiec, DC___________________ Date ____/_____/ 2011