WELCOME TO FAMILY FIRST CHIROPRACTIC CARE

16231 W. 14 Mile Rd. Suite 100
Beverly Hills, MI 48025

PERSONAL INFORMATION

Last: _____ **M.I.** _____ **First:** _____

Preferred Name: _____ **Birth Date:** ____/____/____ **Sex:** ☐ Male ☐ Female

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email: _____

Preferred Contact Method: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email

Emergency Contact: _____ **Relation:** _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Race:
☐ American Indian or Alaska Native
☐ Black or African American
☐ White or Caucasian
☐ Asian
☐ Native Hawaiian or Pacific Islander

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Other
☐ I decline to answer

Primary Physician Name: _____ Date of Last Visit: _____

Address: _____ Phone Number: _____

REVIEW OF SYSTEMS

Please mark whether you have problems with any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Weight Loss	☐	☐	Asthma/Chronic Cough	☐	☐	Joint Pain or Stiffness
☐	☐	Fatigue	☐	☐	Emphysema/COPD	☐	☐	Muscle Pain or Soreness
☐	☐	Fever or Chills	☐	☐	Difficulty Swallowing	☐	☐	Redness/Swelling of Joints
☐	☐	Weakness	☐	☐	Nausea or Heartburn	☐	☐	Headaches/Migraines
☐	☐	Vision Loss/Changes	☐	☐	Change in Appetite	☐	☐	Back or Neck Pain
☐	☐	Hearing Loss/Changes	☐	☐	Change in Bowel Function	☐	☐	Jaw Pain/TMJ Problems
☐	☐	Sinus Problems	☐	☐	Change in Bladder Function	☐	☐	Arthritis
☐	☐	Sore Throat	☐	☐	Constipation or Diarrhea	☐	☐	Bone Fractures/Dislocations
☐	☐	Mouth Sores	☐	☐	Change in Urinary Frequency	☐	☐	Osteoporosis
☐	☐	Chest Pain or Discomfort	☐	☐	Burning or Pain with Urination	☐	☐	Skin Rashes, Itching or Dry Skin
☐	☐	Shortness of Breath	☐	☐	Incontinence	☐	☐	Hair or Nail Changes
☐	☐	Heart Palpitations	☐	☐	Blood in Urine or Stool	☐	☐	Dizziness
☐	☐	Swelling of Limbs	☐	☐	Prostate Problems	☐	☐	Fainting
☐	☐	Stroke/High Blood Pressure	☐	☐	Thyroid Problems	☐	☐	Epilepsy/Seizures
☐	☐	Anemia	☐	☐	Heat or Cold Intolerance	☐	☐	Numbness or Tingling
☐	☐	Bleeding Disorders	☐	☐	Night Sweats	☐	☐	Anxiety/Depression
☐	☐	Swollen Glands/Lymph Nodes	☐	☐	Frequent Urination or Thirst	☐	☐	Memory Loss
☐	☐	Autoimmune Disease	☐	☐	Diabetes (Type I or Type 2?)	☐	☐	Difficulty Sleeping
☐	☐	Cancer	☐	☐	Fibromyalgia/Chronic Fatigue	☐	☐	Allergies

FEMALES ONLY:

Are you currently pregnant? ☐ Yes ☐ No Have you ever given birth? ☐ Yes ☐ No # of Kids: _____

Type of Birth: ☐ Vaginal ☐ C-Section Painful or Abnormal Menstrual Cycle? ☐ Yes ☐ No

First Name: _____ Last Name: _____ DOB: _____ Exam Date: _____

MEDICAL HISTORY

Please list any other serious conditions or illnesses you currently or previously had on the chart below.

Condition	Date of Diagnosis	Diagnosed By
1.		
2.		
3.		

Please list any accidents, injuries or traumas you have experienced in the chart below.

Accident/Trauma/Injury	Date of Injury	Treated By
1.		
2.		
3.		

Please list ALL surgeries and hospitalizations you have had in the chart below.

Reason for Surgery/Hospitalization	Date
1.	
2.	
3.	

List any known allergies, including drug allergies and the reaction you experience.

Allergy	Reaction
1.	
2.	

Are you taking ANY OTC medication? ☐ Yes ☐ No **Are you taking ANY prescription medications?** ☐ Yes ☐ No

Please list <u>ALL</u> medications you are taking in the chart below.

Name of Medication	Dosage	Prescribed By	Name of Medication	Dosage	Prescribed By
1.			4.		
2.			5.		
3.			6.		

To the best of your knowledge, are you up to date on all immunizations? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

Please indicate who in your family has had arthritis, cancer, diabetes, high blood pressure, stroke, heart problems, genetic disorders, mental health issues or any other serious health issues in the chart below.

Father	Mother	Grandfather	Grandmother	Sibling	Children

First Name: _____ Last Name: _____ DOB: _____ Exam Date: _____

SOCIAL HISTORY

Occupation: _____ **Employer:** _____

Do you currently work: ☐ Full-Time ☐ Part-Time ☐ Currently Unemployed ☐ Retired

What is your primary work position? ☐ Seated ☐ Standing ☐ Other _____

What are your job requirements? ☐ Lifting ☐ Bending ☐ Carrying ☐ Twisting ☐ Stooping ☐ Walking ☐ Other: _____

Does your job make symptoms worse? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed **# of Children:** _____

How often do you exercise? ☐ Never ☐ 1-2 days/week ☐ 3-4 days/week ☐ 5+ days/week

What does your exercise routine consist of? _____

Smoking Status: ☐ Non-smoker ☐ Current Smoker ☐ Former Smoker

How many years have or did you smoke? _____ Number of packs per day? _____ When did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No Number of drinks per week: _____

Number of caffeinated beverages per day: _____ **How much water do you drink per day?** _____

How would you rate your current stress level? ☐ Mild ☐ Moderate ☐ High

Please describe your overall health right now: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

REASON FOR VISIT

What is the reason for your visit today? ☐ Headaches ☐ Neck Pain ☐ Lower Back Pain ☐ Mid-Back Pain ☐ Upper Back Pain ☐ Other _____

Does the pain radiate, shoot or travel anywhere? ☐ Yes ☐ No **If so, where?** _____

When did this start? _____

_____

How did this start? _____

_____

Is this due to a(n): ☐ Auto Accident ☐ Work Injury ☐ Personal Injury/Lawsuit ☐ N/A

Since it started, my symptoms have been getting: ☐ Worse ☐ Better ☐ Staying the same

My symptoms are present: ☐ 25% of the day ☐ 50% of the day ☐ 75% of the day ☐ 100% of the day

Have you had similar problems in the past? ☐ Yes ☐ No **If so, when?** _____

Were you treated for this problem in the past? ☐ Yes ☐ No **If so, by who?** _____

Have you had any other recent treatment for this condition? ☐ Yes ☐ No

Doctor's Name: _____ Date Consulted: _____

Diagnosis: _____ Treatment: _____

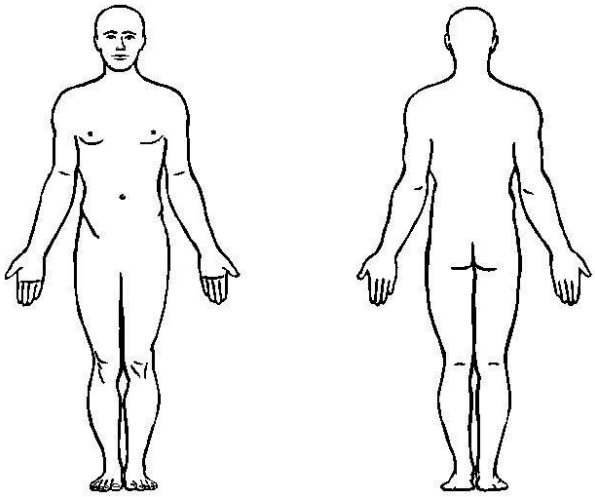
How were you referred to our office? ☐ Online/Website ☐ Family Member ☐ Friend ☐ Close to home/work ☐ Physician/Health Care Provider ☐ Other: _____

First Name: _____ Last Name: _____ DOB: _____ Exam Date: _____

What do your symptom(s) feel like?

☐ Sharp	☐ Sore	☐ Spasms	☐ Stabbing	☐ Tingling
☐ Dull	☐ Tight	☐ Shooting	☐ Throbbing	☐ Numbness
☐ Aching	☐ Stiff	☐ Cramping	☐ Burning	☐ Other:

Please circle or mark on the body diagram to indicate where you are having pain and/or symptoms.



What aggravates your symptoms?

☐ Sitting	☐ Driving	☐ Lifting
☐ Standing	☐ Getting up from chair	☐ Bending
☐ Laying down	☐ Stair climbing	☐ Twisting
☐ Walking	☐ Inactivity/Sleeping	☐ Reaching
☐ Running	☐ Desk Work	☐ Sneezing/Coughing
☐ Physical Activity	☐ House Work	☐ Stress
☐ Exercise	☐ Personal Hygiene	☐ Other:

What relieves your symptoms?

☐ Rest	☐ Chiropractic	☐ Heat
☐ Sitting	☐ Stretching	☐ Ice
☐ Standing	☐ Exercises	☐ Supplements
☐ Laying down	☐ Physical Therapy	☐ Nothing
☐ Medication	☐ Massage	☐ Other:

Please rate your pain:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Moderate Pain — Unbearable Pain

Symptoms are the most severe:

☐ In the Morning	☐ In the Afternoon	☐ In the Evening
☐ During Activities	☐ After Activities	☐ At night/Sleeping
☐ Symptoms are constant and do not change		☐ Other:

This condition is interfering with my:

☐ Personal Hygiene	☐ Housework
☐ Daily Routine	☐ Social Activities
☐ Work Activities	☐ Mobility

☐ Patient's Initials

I give permission for Family First Chiropractic to share my clinical records with my other health care providers.

☐ Patient's Initials

To the best of my knowledge the questions on this form have been answered accurately. I understand that providing incorrect or incomplete information can have a negative effect on treatment outcomes. It is my responsibility to inform Family First Chiropractic Care of any changes in my health status.

Signature: _____ **Date:** _____

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