Patient Condition

Reason for today's visit: _____ When did symptoms appear?_____

Is this condition getting progressively worse? Yes No

Rate severity of your pain on a scale from 1 (least) to 10 (severe) _____

Description of Pain Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Other: _____

Is the pain: Constant Frequent Intermittent Occasional

Activities or movements that aggravate your condition: Sitting Standing Walking Bending
Lying Down Daily Routine Other: _____

Health History

What treatment have you already received for your condition?
Surgery (Date) _____ Physical Therapy Chiropractic Services Other_____

Medications (list):_____

Date of last: Physical Exam _____ Spinal X-Ray _____ MRI_____

Any changes in overall health? _____

Please provide date and description of any Injuries/Surgeries you have had.

_____

_____

If you have had any of the following please circle the condition:

AIDS/HIV	Emphysema	Epilepsy	Mononucleosis	Stroke
Osteoporosis	Allergy Shots	Fractures	Multiple Sclerosis	Suicide Attempt
Anemia	Glaucoma	Mumps	Measles	Thyroid Issues
Appendicitis	Pacemaker	Tumors	Venereal Disease	Tuberculosis
Arthritis	Parkinson's	Hepatitis	Pinched Nerve	Bleeding Disorder
Herniated Disk	Herpes	Prosthesis	High Blood Pressure	Prostate Issues
High Cholesterol	Cancer	Diabetes	Psychiatric Care	Kidney Disease
Liver Disease	Rheumatic Fever	Arthritis	Migraines	Other

Accident Information

Is your visit today due to an auto, Workers Compensation or Personal Injury? Yes No
If yes please inform front desk, Thank You!

How did you hear about us? _____

Back and Body Chiropractic **55130 Van Dyke** Shelby Township, MI 48317

New Patient Intake Form

Name: _____ Today's Date: _____

Address: _____
Street Apt # City State Zip

Phone Numbers: _____ _____
Home Cell

Sex: Male Female Birth Date: _____ E-Mail _____

Occupation: _____ Employer: _____

Single Married Spouse's Name: _____ Number of Children: _____

In case of an emergency, contact

Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____

Insurance Information

Who is responsible for this account? _____ Relationship to Patient: _____

Insurance Company Name: _____ Benefit Phone Number: _____

Card Holders Name: _____ Card Holders DOB: _____

Contract #: _____ Group #: _____ Plan Code: _____

Additional Insurance

Insurance Company Name: _____ Benefit Phone Number: _____

Card Holders Name: _____ Card Holders DOB: _____

Contract #: _____ Group #: _____ Plan Code: _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage and assign **Back and Body Chiropractic** to all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Signature Date

Relationship if legal guardian: _____