Kramer Chiropractic
20414 Farmington Rd, LIVONIA, MI 48152
248.615.1533

New Patient History Form

Date:______________________

Name: ____ Address:__________________________________

City:________________________________ State: _____________ Zip Code:_____________

Date of Birth:____________ Sex: □ M □ F Height:__________ Weight:__________

Home Phone: _______________ Cell Phone:____________________ Email:_________________________

Business Employer:_________________________ Type of Work:_______________________ □ Part □ Full Time

Referred to this Office by: _________________________________

Name and number of Emergency Contact:____

Relationship: ____

Personal Health Insurance Carrier: __________________________ Ins. Card Number:______________________

Insured Persons Name:_____________________________ Date of Birth of Insured Person:_________________

Primary Care Physician: ____________________ City: ________________ Phone Number:__________________

Current Health Condition

1. Primary Complaint:____
2. When did this problem start: _____________________ Have you had this condition before: Y /N
3. Describe the Pain: □ Sharp □Dull □Throbbing □Burning □Other ______________________
4. Rate your pain on a scale of 1-10, 10 being bedridden __________________
5. Briefly How has the pain affected your life:

   ____

Major Accidents, Injuries, falls, and/or Hospitalizations (excluding surgery)

1. Type _________________________________When___________ Hospitalized? □ YES □ NO
2. Type _________________________________When___________ Hospitalized? □ YES □ NO
3. Type _________________________________When___________ Hospitalized? □ YES □ NO

For office use only: L R BP_________ P_________

Past Health History

Surgeries and Year: □NONE □Appendectomy____ □Gall Bladder____ □Hernia____

□Cardiac Surgery_______ □ Disc Surgery_____ □Back/Neck spinal _____ □Broken Bones______

□Other ____

CHECK OFF ANY OF THE FOLLOWING DISEASES YOU HAVE/HAD:

□Cancer □Heart Disease □Diabetes □Mental Disorder □Arthritis □Anemia □Epilepsy

□Other ____

Have you tested positive for HIV □YES □NO

DAILY INTAKE

□Coffee Amt per week ____

□Tea Amt per week ___

□Alcohol Amt per week ____

□Cigarettes Amt per week ___

□White Sugar Amt per week ____

Exercise

□None

□Mild Type_________________

□Moderate Type _________________

□Competitive Type _________________

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL
□HEADACHES
□Neck Pain
□Shoulder/ Arm Pain
□ Wrist Pain – CTS
□Mid Back Pain
□Low Back Pain
□Hip/ Knee Pain
□Leg/Foot Pain
□Difficulty Walking
□Joint Stiffness
□ None

NERVOUS SYSTEM
□Stress
□Numbness/ Burning
□Paralysis
□ Dizziness
□Forgetfulness
□ADD/ ADHD
□Easily Confused
□Depression
□Seizures/ Convulsions
□Tingling Extremities
□Fatigue
□Loss of Sleep
□Fever
□None

GASTRO-INTESTINAL
□Poor/ Excessive Appetite
□Excessive Thirst
□Frequent Nausea
□Vomiting
□Diarrhea/ Constipation
□Hemorrhoids
□Liver Problems
□Gallbladder - Burping
□Weight Trouble
□Abdominal Cramps
□Gas Bloating After Meals
□Reflux/ Heartburn/Ulcer
□ None

C-R-V
□Stroke
□Chest pain
□Short Breath
□High Blood Pressure
□Irregular Heartbeat
□Heart Problem
□Lung Problems/ Congestion
□Ankle Swelling
□ None

FAMILY HISTORY
□Diabetes
□Heart Disease
□ Stroke
□High Blood Pressure
□Cancer:__________
□ None

GENITO-URINARY
□Bladder Problems
□Painful/ Frequent Urination
□Kidney Stones/ Infections
□Dribble Urine

FEMALES ONLY:
When was your last period:
____
Are you Pregnant
□ YES □ NO □ NOT SURE

ENT
□Sore Throat
□Vison Problems
□Ear Aches
□Sinus-Pressure/ Infections
□Hearing Difficulty
□Allergies (type) _____________
□ None

MALE/ FEMALE
□Menstrual Cramps
□Prostate/ Sexual Dysfunction
□Menstrual Irregularity
□ Breast Pain/ Lumps
□Other________________

ACTIVITIES OF LIFE

Please Identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES	EFFECT:			
Carrying Children/ Groceries	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Sit to Stand	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Climb Stairs	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Pet Care	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Extended Computer use	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Lift Children/ Groceries	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Read/ Concentrate	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Getting Dressed	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Shaving	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Sexual Activities	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Sleep	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Static Sitting	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Static Standing	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Yard Work	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Walking	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Washing/ Bathing	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Sweeping/ Vacuuming	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Dishes	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Laundry	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Garbage	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Driving	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform
Other: _______________	□ No Effect	□ Painful (can do)	□Painful (Limits)	□Unable to Preform

List Prescription & Non- Prescription drugs you take:

____

____

Patient Signature: ____ **Today's Date:** __/__/__

This Office conforms to current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk

Patient Signature: ____ **Today's Date:** __/__/__

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare and necessary and forms assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me or charge directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the doctor to treat my condition, as he or she deems appropriate through use of manipulation throughout my spine. The x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient at the office. The patient also agrees that he or she is responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medical diagnose conditions, nor for any medical diagnosis.

The statements made on this form are accurate to the best of my recollection and I agreed to allow this office to examine me for further evaluation.

Patient Signature: ____ **Today's Date:** __/__/__

Informed Consent

Regarding: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of healthcare, hold certain risks. While the risks are more often very minimal, in rare cases, complications such as sprain/ Strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance her One million to one per Two million, has been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Kramer chiropractic PC have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do here by consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course at my care.

Patient Signature: ____ **Today's Date:** __/__/__