



# WELCOME

**COOK CHIROPRACTIC CLINIC**

51540 Van Dyke  
Shelby Twp., MI 48316  
Telephone: (586) 731-7730

## PATIENT INFORMATION

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Patient SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ 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 insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

## PHONE NUMBERS

Home \_\_\_\_\_ Cell \_\_\_\_\_

E-mail address \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an accident?  Yes  No Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom, have you made a report of your accident?

Auto Insurance  Employer  Worker Comp.  Other

Attorney Name (if applicable) \_\_\_\_\_

## PATIENT CONDITION

Reason for Visit \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale for 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching

Shooting  Burning  Tingling  Cramps  Stiffness  Swelling  Other

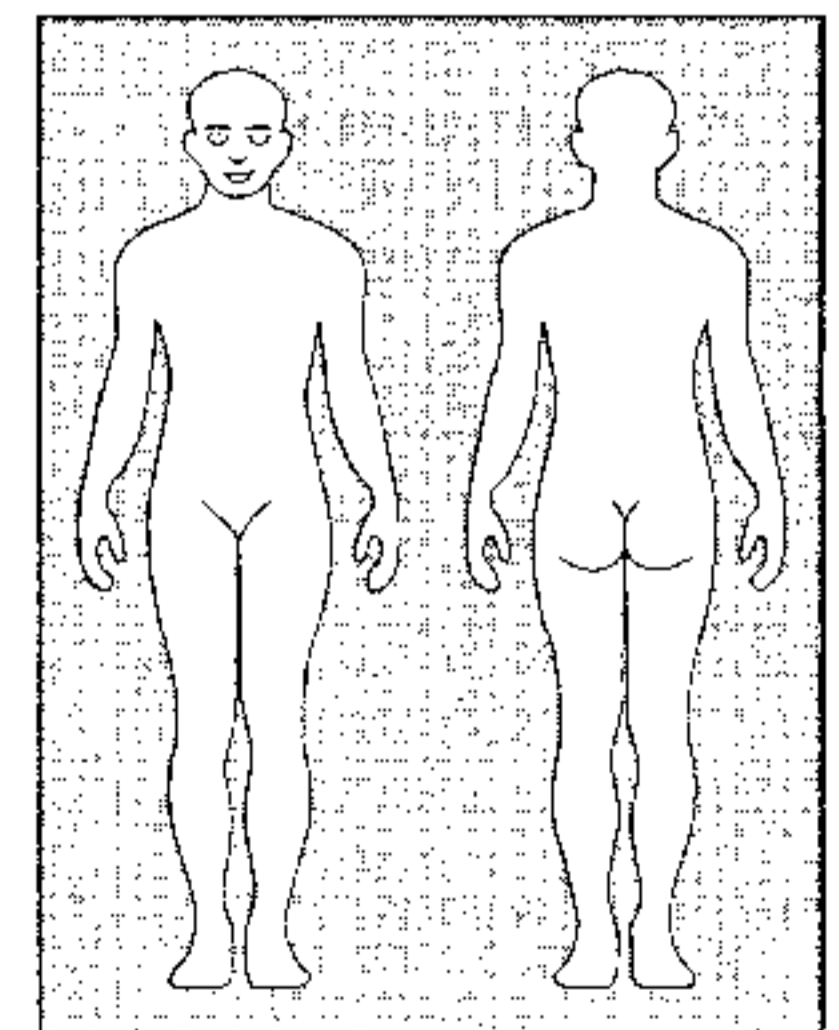
How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform  Sitting  Standing  Walking  Bending  Lying Down

Have you seen a chiropractor for this or any other condition?  Yes  No If yes, for what? \_\_\_\_\_



# HEALTH HISTORY

What treatment have you already received for your condition?  Medications  Surgery  Physical Therapy  
 Chiropractic Services  None  Other \_\_\_\_\_

Name and address of other doctor(s) who have treated you for your condition \_\_\_\_\_

Date of Last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
 Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
 Dental X-Ray \_\_\_\_\_ MRI, CT-Scan, Bone Scan \_\_\_\_\_

(Please check any of the following that give you difficulty or you have had before )

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Headaches 784.0              | <input type="checkbox"/> Fainting 780.2                           | <input type="checkbox"/> Ulcers 534.9                   | <input type="checkbox"/> Shortness of breath 786.09   |
| <input type="checkbox"/> Shooting head pains 784.0    | <input type="checkbox"/> Loss of balance 781.2                    | <input type="checkbox"/> Numbness legs or feet 782.0    | <input type="checkbox"/> Mid-back pain 724.1          |
| <input type="checkbox"/> Sinus trouble 473.9          | <input type="checkbox"/> Ringing in ears 388.3                    | <input type="checkbox"/> Constipation 564.0             | <input type="checkbox"/> Heart attacks 410.9          |
| <input type="checkbox"/> Loss of smell 781.1          | <input type="checkbox"/> Blurred vision 368.0                     | <input type="checkbox"/> Kidney trouble 593.9           | <input type="checkbox"/> High blood pressure 401.9    |
| <input type="checkbox"/> Allergies 995.3              | <input type="checkbox"/> Lights bother eyes 368.13                | <input type="checkbox"/> Menstrual cramps/pain 625.3    | <input type="checkbox"/> Low blood pressure 458.9     |
| <input type="checkbox"/> Hayfever 477.8               | <input type="checkbox"/> Neck pain 723.1                          | <input type="checkbox"/> Menstrual irregularity 626.4   | <input type="checkbox"/> Anemia 285.9                 |
| <input type="checkbox"/> Asthma 493.9                 | <input type="checkbox"/> Muscles spasms in neck 781.0             | <input type="checkbox"/> Diabetes 250.0                 | <input type="checkbox"/> Stomach trouble 789.0        |
| <input type="checkbox"/> Loss of taste 781.1          | <input type="checkbox"/> Grinding in neck 719.68                  | <input type="checkbox"/> Sleeping problems 780.5        | <input type="checkbox"/> Nerves and nervousness 799.2 |
| <input type="checkbox"/> Inflammation of throat 462.0 | <input type="checkbox"/> Tightness of shoulders and arms 728.85   | <input type="checkbox"/> Painful joints 719.4           | <input type="checkbox"/> Inner tension 799.2          |
| <input type="checkbox"/> Thyroid trouble 246.9        | <input type="checkbox"/> Pain in shoulders and arms 719.4         | <input type="checkbox"/> Swollen joints 719.0           | <input type="checkbox"/> Irritability 799.2           |
| <input type="checkbox"/> Twitching of face 351.9      | <input type="checkbox"/> Pins and needles in arms and hands 782.0 | <input type="checkbox"/> Pins and needles in legs 782.0 | <input type="checkbox"/> Gall bladder trouble 575.9   |
| <input type="checkbox"/> Loss of memory               | <input type="checkbox"/> Cold hand 782.0                          | <input type="checkbox"/> Swollen ankles 782.3           | <input type="checkbox"/> Indigestion 536.8            |
| <input type="checkbox"/> Fatigue 780.7                | <input type="checkbox"/> Numbness in arms/hands 782.0             | <input type="checkbox"/> Cold feet 782.0                | <input type="checkbox"/> Intestinal gas 787.3         |
| <input type="checkbox"/> Depression 311.0             | <input type="checkbox"/> Cold hand/fingers 782.0                  | <input type="checkbox"/> Pain in legs and feet 719.46   | <input type="checkbox"/> Low back pain 724.2          |
| <input type="checkbox"/> Dizziness 780.4              | <input type="checkbox"/> Tonsillitis 784.0                        | <input type="checkbox"/> Hip pain 719.45                | <input type="checkbox"/> Hernia 550.01                |
| <input type="checkbox"/> Spinal curvature 737.43      | <input type="checkbox"/> Prostate trouble 601.4                   | <input type="checkbox"/> Hiv / Aids                     | <input type="checkbox"/> Stroke 436.0                 |
| <input type="checkbox"/> Chest pain 786.5             |   |   | <input type="checkbox"/> Bed wetting 788.3            |
| <input type="checkbox"/> Cancer                       |   |   |   |

<p><b>EXERCISE</b></p> <input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Daily <input type="checkbox"/> Heavy	<p><b>WORK ACTIVITY</b></p> <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	<p><b>HABITS</b></p> <input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Coffee/Caffeine Drinks <input type="checkbox"/> High Stress Level	Packs/Day _____ Drinks/Week _____ Cups/Day _____ Reason _____
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Are you pregnant?  Yes  No Due Date \_\_\_\_\_

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone _____	_____	_____