COOK CHIROPRACTIC CLINIC

51540 VAN DYKE SHELBY TWP MI 48316

DATE: ______________________

PATIENT INFORMATION

Name: ____________________________ ☐ M ☐ F Birthdate: ___/___/___ Age: ______

Address: ____________________________ City: ____________________ State: ________ Zip: _______

Social Security Number: ________-________-________ ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Home #: ____________________ Cell #: ______________________ Email: ______________________________

Preferred contact method: ☐Home ☐Work ☐Cell

Are you interested in receiving text appt. reminders? ☐ Y ☐ N If yes: Cell phone carrier ________________________

Spouse's Name: ____________________________ Do you have children? ☐ Y ☐ N How Many? ______________

RACE: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

ETHNICITY: ☐ American Indian ☐ Asian ☐ Black, African American ☐ Native Hawaiian ☐ White ☐ Other ☐ Decline

How did you hear about us? ____

EMERGENCY CONTACT

Name: ____________________________ Relationship: ______________________ Phone: ____________________

INSURANCE INFORMATION

Insurance Company: ________________________ Contract No. ______________________ Group No. ____________

OCCUPATION

Employer Name: ______________________________ Employer Phone No. ____________________________

Occupation: ____________________________ My job duties include: ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor

PATIENT COMPLAINTS (Please check all that apply)

Current	Past		Current	Past		Current	Past	
☐	☐	Neck pain	☐	☐	Mid back pain	☐	☐	Feet Numbness ☐L / ☐R
☐	☐	Neck Stiffness	☐	☐	Mid back stiffness	☐	☐	Constipation
☐	☐	Headaches	☐	☐	Shoulder pain ☐L / ☐R	☐	☐	Poor circulation
☐	☐	Dizziness	☐	☐	Shoulder tightness ☐L / ☐R	☐	☐	High blood pressure
☐	☐	Head feels heavy	☐	☐	Rib pain ☐L / ☐R	☐	☐	Asthma
☐	☐	Twitching of face	☐	☐	Pain in side ☐L / ☐R	☐	☐	Loss of balance
☐	☐	Grating in neck	☐	☐	Chest Pain ☐L / ☐R	☐	☐	Loss of taste
☐	☐	Muscle spasms in neck	☐	☐	Low back pain	☐	☐	Fatigue
☐	☐	Arm pain ☐L / ☐R	☐	☐	Low back stiffness	☐	☐	Nervousness
☐	☐	Arm Numbness ☐L / ☐R	☐	☐	Hip pain ☐L / ☐R	☐	☐	Sleeping trouble
☐	☐	Wrist pain ☐L / ☐R	☐	☐	Leg pain ☐L / ☐R	☐	☐	Arthritis
☐	☐	Hand Numbness ☐L / ☐R	☐	☐	Leg numbness ☐L / ☐R	☐	☐	Painful joints
☐	☐	Cold Hands ☐L / ☐R	☐	☐	Knee pain ☐L / ☐R	☐	☐	Swollen joints
☐	☐	Pain in ears ☐L / ☐R	☐	☐	Pain in feet ☐L / ☐R	☐	☐	Menstrual irregularity

HISTORY

Are your complaints related to an accident? ☐ yes ☐ no If yes, ☐ work related ☐ auto ☐ other ___________________

Does your pain interfere with your? ☐ Work ☐ Sleep ☐ Daily Routines ☐ Recreation

Is it possible that you are pregnant? ☐ no ☐ yes

Have you ever had any injuries, accidents, or falls *(even if you think you were not hurt at the time)*? ☐ No ☐ Yes, if yes please indicate below.

When? Month_______ Year_______ Type of injury: ____

When? Month_______ Year_______ Type of injury: ____

When? Month_______ Year_______ Type of injury: ____

Please indicate what treatment/testing you have already received for these complaints

☐ Chiropractic ☐ Physical Therapy ☐ Medications ☐ Surgery ☐ MRI ☐ CT Scan ☐ None

☐ Other ____

Please indicate which doctors you have already seen for these complaints

Doctor: ___________________________ City _________________________ Phone No. _______________________________

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Doctor: ___________________________ City _________________________ Phone No. _______________________________

SURGERIES

Surgery	Month/Year	Surgery	Month/Year
_____________________________	__________	____________________________	__________
_____________________________	__________	____________________________	__________
_____________________________	__________	____________________________	__________

Have you had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Anemia	☐	☐	Anxiety
☐	☐	Bleeding disorders	☐	☐	Cancer	☐	☐	Chemical dependency
☐	☐	Depression	☐	☐	Diabetes	☐	☐	Epilepsy/Siezures
☐	☐	Fractures	☐	☐	Heart disease	☐	☐	Hepatitis
☐	☐	Hernia	☐	☐	Herniated disc	☐	☐	High cholesterol
☐	☐	Multiple sclerosis	☐	☐	Osteoporosis	☐	☐	Pacemaker
☐	☐	Parkinson's disease	☐	☐	Polio	☐	☐	Prostate problems
☐	☐	Prosthesis	☐	☐	Psychiatric care	☐	☐	Stroke
☐	☐	Suicide attempt	☐	☐	Thyroid problems	☐	☐	Tumors
☐	☐	Ulcers	☐	☐	Other ____			

MEDICATIONS, VITAMINS, AND SUPPLEMENTS

Medication	Dosage	Vitamin/Supplement	Dosage
______________________________	__________	____________________________	__________
______________________________	__________	____________________________	__________
______________________________	__________	____________________________	__________
______________________________	__________	____________________________	__________

ALLERGIES

ALLERGIC TO:________________________ REACTION: ☐ anaphylaxis ☐ difficulty breathing ☐ nausea ☐ rash ☐ swelling ☐ hives ☐ vomiting ☐ other

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ALLERGIC TO:________________________ REACTION: ☐ anaphylaxis ☐ difficulty breathing ☐ nausea ☐ rash ☐ swelling ☐ hives ☐ vomiting ☐ other

SOCIAL

My exercise level is: ☐ Intense ☐ Moderate ☐ Light ☐ Minimal ☐ None

My habits include: ☐ Smoking/Tobacco use _______packs/day current smoker ☐ never smoked ☐ former smoker

☐ Alcohol _______drinks/week

☐ Coffee _________cups/day ☐ Soda Pop _________cups/day ☐ Tea _________cups/day

☐ Recreational drug use ☐ Other ____

FAMILY

Please mark the conditions that relate to your parents, siblings, or grandparents.

	Diabetes	Heart Disease	Cancer	Stroke	Thyroid	Arthritis	Mental Illness	Auto Immune	Back/ Spine	High Blood Pressure	Osteoporosis	High cholesterol
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother(s) **# of: _______**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister(s) # of: _______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother (maternal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather (maternal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother (fraternal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather (fraternal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

CONSENT FOR TREATMENT AND X-RAY POLICY

It is understood and agreed the amount paid Cook Chiropractic Clinic P.C. for x-rays, is for examination only and the x-ray negatives will remain the property of this clinic, being on file where they may be seen at any time while a patient of this clinic. The patient also agrees he/she is responsible for payment for all bills incurred at this clinic.

(x-rays are not transferable)

I hereby authorize Dr. William S. Cook and whomever he may designate as his assistants to administer treatment as he so deem necessary to myself ____.

Signed:____ Date:__________________________

Witness:____ Date: __________________________

Acknowledgement of Receipt of Office Privacy Policy

I acknowledge that Cook Chiropractic Clinic, P.C.'s "Notice of Privacy Practices" has been provided to me.

I understand I have the right to review Cook Chiropractic Clinic, P.C. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Cook Chiropractic Clinic, P.C.. The Notice of Privacy Practices for Cook Chiropractic Clinic, P.C. is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Cook Chiropractic Clinic P.C.'s duties with respect to my protected health information.

Cook Chiropractic Clinic P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling Cook Chiropractic Clinic, P.C. and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____ _____________

Signature of Patient of Personal Representative Date

____

Name of Patient or Personal Representative

____

Description of Personal Representatives Authority