INTAKE FORM

THE CREEK
CHIROPRACTIC AND WELLNESS

510 E. Columbia Ave.,
Battle Creek, MI

Name _____Today's Date_____

Birthdate _____ Age_____ Gender at birth: ❑ Male ❑ Female

How you hear about us? ❑Google, ❑ Google, ❑ Website, ❑ Instagram, ❑ Facebook, ❑ Event, ❑ Other

❑ Family/Friend _____

Have you been to a chiropractor before? □ No □ Yes

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Significant Other's Name _____

Kid's Names and Ages _____

Your Employer _____ Type of Work _____

e-Mail Address _____

Emergency Contact _____ ph # _____

Name of Medical Doctor(s):

_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize The Creek Chiropractic & Wellness to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is:
    - ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long-term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Pain radiates to_____
❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Pain radiates to_____
❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Pain radiates to_____
❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Pain radiates to_____
❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

6. What makes it better? _____

7. What makes it worse? _____

8. What Doctor's have you seen for this? _____

_____

9. Type of treatment: _____

10. Results: _____

NOTES: _____

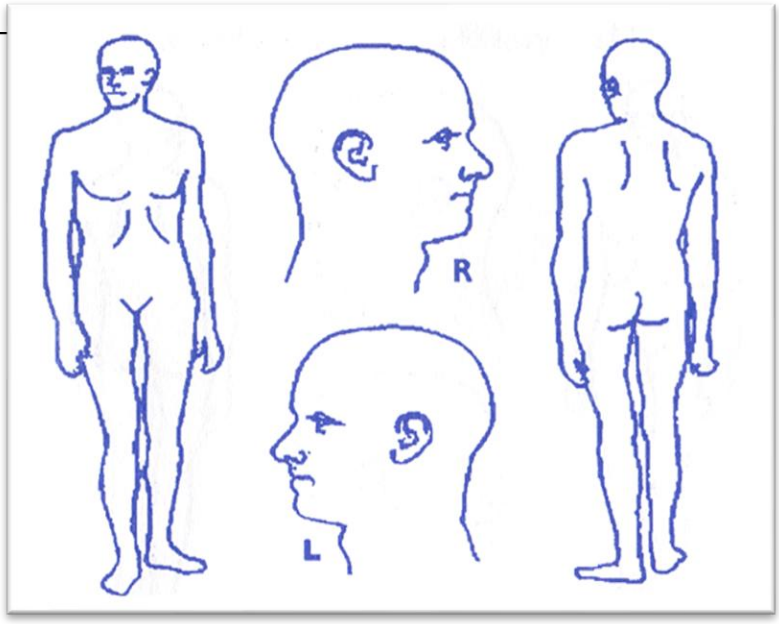
_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark all areas of concern.



Health History

THE CREEK
CHIROPRACTIC AND WELLNESS

510 E. Columbia Ave.,
Battle Creek, MI

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. **List any medications you are taking:**

_____

2. **Please list all doctors you are currently seeing:** _____
3. **Has any Doctor or other professional advised you to "Go to a Chiropractor ":** ❑ No ❑ Yes, Name _____

_____

PAST HISTORY

4. **List any past auto collisions:**_____ **Was any care received?**_____
5. **List any past work injuries:** _____ **Was any care received?**_____
6. **List any past sport, recreational, or home injuries**_____
7. **Please describe any past conditions and treatment received:** _____

_____

8. **Please list any past hospitalizations and surgeries:** _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____