

GATEWAY CHIROPRACTIC, P.C.
14930 La Plaisance Rd #134 Monroe, MI 48161
(734) 242-4422

NAME (last) _____ (first) _____ (MI) _____

Address _____
(Street) (City) (State) (Zip)

Home Phone # _____ Work # _____ Cell # _____

Birth Date _____ Email _____

Height _____ Weight _____ Do you use tobacco? _____

Marital Status: S M OTHER SS# _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Whom may we thank for referring you to us/how did you hear about us? _____

Health INS: BCBS PPOM AETNA PARAMOUNT NONE OTHER _____

Policy Holder: _____ Policy Holders DOB: _____

Is this a **Workers' Comp claim?** _____ **Auto Policy Claim?** _____ **Personal Injury Lawsuit?** _____

List medical doctors seen within past year:

Name _____	City _____	State _____	When _____
Name _____	City _____	State _____	When _____

Date of last physical examination _____

List all surgeries:

Type _____	When _____
Type _____	When _____
Type _____	When _____

Past accidents or injuries:

Type _____	When _____	Hospitalized? Yes _____ No _____
Type _____	When _____	Hospitalized? Yes _____ No _____
Type _____	When _____	Hospitalized? Yes _____ No _____

List medications and/or vitamins & minerals you are taking:

Type _____	For _____	How long _____
Type _____	For _____	How long _____
Type _____	For _____	How long _____

Present Complaint

What is the reason you are visiting our office today? _____

When did this begin? _____ Have you ever had this problem before? **Y** **N** When? _____

Did your problem begin Gradually Immediately after an event

If so, explain the event _____

Describe your pain (you may check more than one) Sharp/Stabbing Dull/Achy Numbness
 Weakness Shooting Throbbing

How often are the complaints present? Constant, _____ Hours per day, _____ Days per week, _____ Days per month.

Since your problem began, is the pain: Increasing, Decreasing, Not changing

If your current complaints are associated with an old injury and were aggravated (made worse) by a recent incident, please describe the incident and when it occurred:

Date _____ Description _____

Indicate how your symptoms are affected by physical activity:

_____ Symptoms are unaffected by rest, exercise, etc.

_____ Symptoms increase with, or are made worse by, exercise or physical activity.

_____ Symptoms increase with, or are made worse by, rest or inactivity...

Are your complaints affecting your ability to work or otherwise be active?

_____ No effect.

_____ Some physical restrictions (able to perform light duty work and household tasks).

_____ Need limited assistance with common everyday tasks.

_____ Need assistance often.

_____ Have a significant inability to function without assistance.

_____ Am totally disabled (impaired). Cannot care for self.

Rate the severity of your pain at its least and greatest times by checking two boxes on scale.

0 1 2 3 4 5 6 7 8 9 10

Have you seen another health care professional for this condition? _____ Who? _____

Were any of these tests performed? X Rays MRI CT Scan EMG Other _____

Do you have any vomiting, nausea, fever, chills, or any unexplained weight loss or weight gain? _____

Have you ever broken ribs or had any serious spinal injuries? _____ If yes, please explain to doctor upon examination

WOMEN: Is there any reason to believe that you may be pregnant? _____

PLEASE CONSIDER GETTING YOUR FAMILY UNDER CHIROPRACTIC CARE. STUDYS SHOW BOTH ADULTS AND CHILDREN CAN BENEFIT FROM A HEALTHY SPINE AND NERVOUS SYSTEM.

Past and Present Conditions

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or presently troubled by a listed disorder.

- Headaches _____
- Neck Pain _____
- Low Back Pain _____
- Diabetic problems _____
- Breathing problems _____
- Sinus problems _____
- Eye problems _____
- Indigestion _____
- Skin problems _____
- Constipation _____
- Liver problems _____
- Weight problems _____
- Dizziness _____
- Pins/Needles in arms/hands _____
- Pain in legs and feet _____
- Heart Problems _____
- Asthma _____
- Allergies _____
- Ear problems _____
- Stomach problems _____
- Gall Bladder problems _____
- Bladder problems _____
- Kidney problems _____
- Fatigue _____
- Pain b/w the shoulder blades _____
- Pain in joints _____
- High Blood Pressure _____
- Thyroid problems _____
- Bowel problems _____
- Menstrual problems _____
- Sleeping problems _____

TERMS OF ACCEPTANCE

The goal of the chiropractor is not to diagnose/treat any disease but to locate, analyze, and correct vertebral subluxations. The purpose being to improve joint mechanics and to restore the innate healing mechanisms of the body via a nervous system free of irritation/interference. I consent to the customary examinations, tests and procedures performed at Gateway Chiropractic, P.C. and to routine chiropractic treatment ordered or administered by my chiropractor or other Clinic staff. I recognize that the practice of chiropractic is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of services administered to me in connection with this Agreement. I understand as with any health care procedure that certain complications may rarely occur such as fractures, disc injuries, muscle or vertebral strains, arterial dissection, or others.

* _____ INITIALS

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic. Not limited to but including deductible, co-payment, and any services rejected by my insurance company.

Financial Policies:

-We will try our best to inform you of your insurance benefits, however we cannot be held responsible for what your insurance company tells us over the phone. Your EOB (Explanation of Benefits) is what we have to legally go by.

* _____ INITIALS

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional/chiropractic expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as original

* _____ INITIALS

RELEASE OF INFORMATION

I authorize this clinic to release any patient information from my case to any insurance company, adjuster, and/or attorney involved in my case; and hereby release this clinic of any consequence thereof.

* _____ INITIALS

MISSED APPOINTMENT POLICY

Gateway Chiropractic, P.C. reserves the right to bill any patient for a missed appointment with no advance notice of cancellation or reschedule.

* _____ INITIALS

SIGNATURE _____ DATE _____.