6850 N. Rochester Rd. Rochester Hills, MI 48306
(248)-963-1118 FAX (248)-721-4083

Please allow our staff to make a copy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Today's Date (MM/DD/YYYY)__________________ Whom may we thank for referring you? ____

PERSONAL

Last Name____ First________________________________ Middle(or Initial) _____________

Street Address ____

City ____State/Province____________ ZIP/Postal Code__________________

Home Phone ______________________ Cell ________________________ Email Address ____

Gender ❍Male ❍Female Birth Date (MM/DD/YYYY) __________________ Social Security Number ______________________________

Marital Status ❍Single ❍Married ❍Divorced ❍Widowed ❍Separated Spouse's Name ____

Other Family Members ____

Occupation ____

Employer ____Phone ____________________________

Preferred method of contact ❍Home Phone ❍Cell Phone ❍Work Phone ❍Email

Primary Care Physician ____ Phone____________________________

Emergency Contact ____ Phone Number ________________________________

INSURANCE

Insurance Carrier________________________________ Policy Number ________________________ Carried by ❍Self ❍Spouse ❍Parent

Insured's Last Name _____________________________________ First______________________________________ Middle Initial)_______

Insured's Birth Date (MM/DD/YYYY) __________________________________ Social Security Number _____________________________

Insured's Employer ____ Phone _______________________________

Street Address ____

City ____ State/Province___________ZIP/Postal Code__________________

PREVIOUS CHIROPRACTIC CARE

Have you seen a Chiropractic Physician before? ___ Yes ___ No

Who? ____When? __________________________________

Reason for Visit at that time: ____

How did you respond? ____

Name: ______________________________ Date: ______________

The symptom(s) that have prompted me to seek care include: ______________________________

____

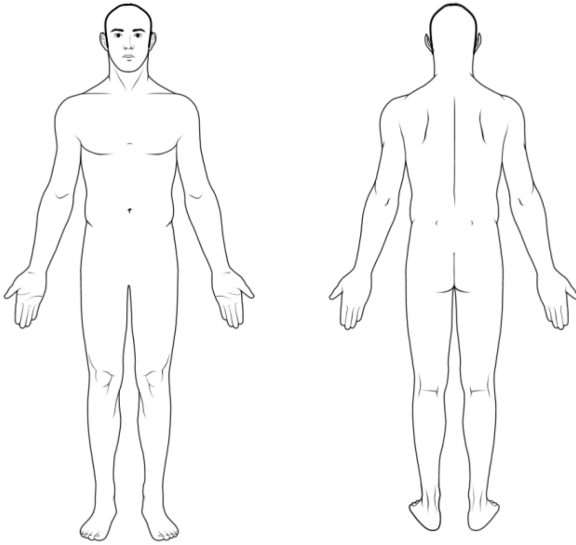
And are the result of: ❍Work Injury ❍Auto Accident ❍Wellness ❍Other ______________

Onset: When did your symptoms begin ______________ Intensity: How much pain does it cause? 0 1 2 3 4 5 6 7 8 9 10
No pain moderate severe

Duration and timing: How often do you feel your symptoms? ❍Constant ❍Comes and goes How often? ______________

Symptoms: What does it feel like? Numbness Tingling Stiffness Dull Aching Cramps Nagging Sharp Burning Shooting Throbbing Stabbing Other: ______________

Location: Were does it hurt? Circle area(s) on the illustration.
X for current condition, **O** for conditions experienced in the past.



What areas, if any, does the pain radiate, shoot or travel?
____

Aggravating/relieving factors: What makes it better or worse,

time of day, movements, certain activities, etc.?

What makes the pain **worse**?
____

What makes the pain **better**?
____

What previous treatments have you done for this condition?
____
____

What else should the Doctor know about your current condition?
____

Activity	Pain	No	Mild	Moderate	Severe
Sitting		❍	❍	❍	❍
Rising out of chair		❍	❍	❍	❍
Standing		❍	❍	❍	❍
Walking		❍	❍	❍	❍
Lying down		❍	❍	❍	❍
Bending over		❍	❍	❍	❍
Climbing stairs		❍	❍	❍	❍
Using a computer		❍	❍	❍	❍
Getting out of car		❍	❍	❍	❍
Driving car		❍	❍	❍	❍
Looking over shoulder		❍	❍	❍	❍
Caring for family		❍	❍	❍	❍

Activity	Pain	No	Mild	Moderate	Severe
Grocery Shopping		❍	❍	❍	❍
Household chores		❍	❍	❍	❍
Light Lifting		❍	❍	❍	❍
Reaching Overhead		❍	❍	❍	❍
Showering/bathing		❍	❍	❍	❍
Dressing self		❍	❍	❍	❍
Getting to sleep		❍	❍	❍	❍
Staying asleep		❍	❍	❍	❍
Concentrating		❍	❍	❍	❍
Exercise		❍	❍	❍	❍
Yard Work		❍	❍	❍	❍
Intimacy	❍	❍	❍	❍	

Family History:

Relative	State of Health Good	State of Health Poor	Age	Illnesses	Age at death	Cause of death
Mother	❍	❍				
Father	❍	❍				
Sister 1	❍	❍				
Sister 2	❍	❍				
Brother 1	❍	❍				
Brother 2	❍	❍				
______	❍	❍				

Are there any other hereditary health issues of which you are aware? ______________

Name ____ Date ______________________

MEDICAL HISTORY

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss	□	□ Ankle/Foot Pain
□	□ Loss of Appetite	□	□ Jaw Pain	□	□ Abdominal Pain
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Arthritis
□	□ Hepatitis	□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder
□	□ Cancer	□	□ General Fatigue	□	□ Tumor
□	□ Muscular Incoordination	□	□ Asthma	□	□ Visual Disturbances
□	□ Chronic Sinusitis	□	□ Dizziness	□	□ Other ______________________________

For Females Only: Birth Control Pills Hormonal Replacement Pregnancy

List all prescription medications you are currently taking ____

List all the over-the-counter medications you are currently taking ____
List all Supplements and Herbs ____

List all surgical procedures you have had ____

Social History:

Alcohol Use	❍Daily	❍Weekly	❍Occasional	How much?_____________________________________	Mercury Filling Yes No
Coffee Use	❍Daily	❍Weekly	❍Occasional	How much?_____________________________________	Recreational Drugs Yes No
Tobacco Use	❍Daily	❍Weekly	❍Occasional	How much?_____________________________________	
Exercising	❍Daily	❍Weekly	❍Occasional	How much?_____________________________________	
Pain Relievers	❍Daily	❍Weekly	❍Occasional	How much?_____________________________________	
Water Intake	❍Daily	❍Weekly	❍Occasional	How much?_____________________________________	

Hobbies: ____

Daily Living:

How much sleep are you getting per night? ______Hours Preferred Sleeping Position: ❍ Back ❍ Side ❍Stomach

Typical Eating Habits: ____

In addition to the main reason for your visit, what are your other health goals? ____

Name ____ Date _________________________

ACKNOWLEDGEMENTS

In order to set clear expectations, improve communication and help you attain the best results, please read each statement and initial your agreement.

_______ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered at Health Loft Chiropractic is based on evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art form from medicine and does not proclaim to cure any named disease or entity.

_______ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_______ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY) ________________________

_______I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information, as an extension of my care in this office.

_______ I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for the payment of any covered or non-covered services that I receive.

_______ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: ____

____ ___________________________

Signature Date

Insurance Policy and Fee Schedules

- Consultation includes practice member history. This is a complimentary service.
- Examination (new patient and established patient) includes one or more of the following: range of motion, motion and/or static palpation, muscle testing, dermatome testing, and leg check.
- Chiropractic Adjustment, this is the actual realignment of the vertebra, a manual or specific instrument spinal adjustment will be delivered to help re-align the vertebra.
- X-rays may be taken with specific views of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to help indicate progress after a period of care.

Release of Authorization/Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits directly to Dr. Marie Palazzolo-Meyer, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for the service when rendered unless other arrangements have been made in advance. I understand that I am Financially responsible for any charges not covered by this assignment.

____

Signature Date