1500 E Beltline, Suite 145
Grand Rapids, MI 49506
Phone: (616) 608-3606
Fax: (616) 551-3233
ClearChiro@gmail.com

Patient Information

Date: _____ SSN: _____ Birthday: _____

First Name: _____ Middle Name: _____ Last Name: _____

Sex: ☐ M ☐ F Height: _____ Weight: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other Spouse Name: _____

Home #: _____ Cell #: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Emergency Contact: _____ Relation: _____ Emergency Phone: _____

How Did You Hear About Us?

☐ A Friend/Relative: _____ ☐ Radio

☐ Dr. Referral: _____ ☐ GR Chamber of Commerce

☐ Advertisement: _____ ☐ Other: _____

Employer Information

Employed: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Homemaker Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Phone: _____ Fax: _____

Email: _____ Website: _____

Insurance Information

Primary Insurance Company: _____

ID/Policy# _____ Group # _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

Insurance Attorney Name: _____ Phone: _____

Insured Information ☐ check box if self (continue to next section)

Name: _____ Birthday: _____

Relationship: ☐ Spouse ☐ Dependent ☐ Other: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Policy # _____ Group/Plan _____

☐ **check if secondary insurance information is available**

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t\Y I-\è Complaint Information

Condition Started on: _____ Experienced Condition Before: ☐Yes ☐ No

Details of how condition began: _____

Pain Level (0-10): _____ Improvement: ☐Better ☐Worse ☐Same

Frequency: ☐Always ☐Hourly ☐Daily ☐Occasionally

Interferes with Activities: ☐Yes ☐No Affects Sleep: ☐Yes ☐No

Aggravates Condition: _____

Improves Condition: _____

Received Treatment before for this condition: ☐Yes ☐No explain: _____

History

Primary Physician:_____ Phone:_____

City: _____ State: _____ Zip: _____

Health Conditions:_____

Previous Chiro Care: ☐Yes ☐No Date: _____ Explain: _____

Medications: _____

Supplements: _____

Broken Bones: ☐Yes ☐No _____

Sprains/Strains: ☐Yes ☐No _____

Hospitalized: ☐Yes ☐No _____

Surgery: ☐Yes ☐No _____

Auto Accident: ☐Yes ☐No _____

Struck Unconscious: ☐Yes ☐No _____

Eating Disorders: ☐Yes ☐No _____

Stroke: ☐Yes ☐No _____

Family Health History: _____

Social History (check all boxes that apply)

	Daily	Weekly	Occasionally	Never
Alcohol	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Homemade Food	☐	☐	☐	☐
Processed Food	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Water	☐	☐	☐	☐

CLEAR CONNECTIONS CHIROPRACTIC

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Health Checklist

- ☐ Allergies _____
- ☐ Arthritis
- ☐ Fatigue
- ☐ Scoliosis
- ☐ Cancer _____
- ☐ Diabetes
- ☐ Sciatica
- ☐ Recent Weight Loss/Gain
- ☐ Headaches
- ☐ Frequent Sinus Infections
- ☐ Nosebleeds
- ☐ Irregular Heart Beat
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Constipation
- ☐ Digestion Problems/Heartburn
- ☐ Kidney Stones
- ☐ Frequent Urination
- ☐ Kidney Infection/UTI
- ☐ Back Pain
- ☐ Swollen Joints
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Numbness
- ☐ Stress
- ☐ Loss of Memory
- ☐ Depression
- ☐ Insomnia/Trouble Sleeping
- ☐ Thyroid Condition
- ☐ Bruise Easily
- ☐ Prostate Trouble
- ☐ Irregular Menstrual Cycle
- ☐ Menstrual Cramps
- ☐ Menopause
- ☐ Hot Flashes
- ☐ Cold Extremities
- ☐ Varicose Veins
- ☐ Chest Pain
- ☐ Alcoholism
- ☐ Other: _____

Patient Signature: _____ Date: _____