CLEAR CONNECTIONS
CHIROPRACTIC

1500 E Beltline, Suite 145
Grand Rapids, MI 49506
Phone: (616) 608-3606
www.ClearConnectionsChiropractic.com

Patient Information

Date: _____ 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: _____ ☐ Advertisement: _____

☐ Dr. Referral: _____ ☐ Other: _____

Employer Information

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

Employer Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Phone: _____

Insurance Information

Primary Insurance Company: _____

ID/Policy# _____ Group # _____

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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Primary Complaint: _____

How & When Condition Began: _____

What **Aggravates** Condition: _____

What **Improves** Condition: _____

Pain Level (0-10): _____

Description (check all that apply): ☐burning ☐shooting ☐sharp ☐dull ☐ache ☐numb ☐other: _____

Frequency: ☐ Constant ☐ Occasional **When** do you notice it most: ☐AM ☐PM

Does the pain **travel:** ☐Yes ☐ No if yes, where to: _____

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

Secondary Complaint: _____

How & When Condition Began: _____

What **Aggravates** Condition: _____

What **Improves** Condition: _____

Pain Level (0-10): _____

Description (check all that apply): ☐burning ☐shooting ☐sharp ☐dull ☐ache ☐numb ☐other: _____

Frequency: ☐ Constant ☐ Occasional **When** do you notice it most: ☐AM ☐PM

Does the pain **travel:** ☐Yes ☐ No if yes, where to: _____

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

☐ I'm not currently experiencing any symptoms; I am primarily interested in **Wellness Care.**

History

Health Conditions: _____

Children: Names/Ages: _____

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 _____

Family History: ☐ Diabetes, ☐ Stroke, ☐ Heart Disease, ☐ Cancer, ☐ Other? _____

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Health Checklist

- □ Weight loss or gain
- □ Fatigue
- □ Weakness
- □ Insomnia/Trouble sleeping
- □ Headaches

- □ Vision Changes
- □ Glaucoma
- □ Cataracts

- □ Decreased hearing
- □ Ringing in ears (tinnitus)
- □ Earache
- □ Nosebleeds
- □ Sinus pain/infections
- □ Sore throat
- □ Allergies: _____

- □ Heart Disease
- □ Chest pain or discomfort
- □ Palpitations
- □ Shortness of breath with activity
- □ Difficulty breathing lying down
- □ Swelling (edema)

- □ Cough (dry or wet, productive)
- □ Wheezing
- □ Painful breathing
- □ Asthma

- □ Heartburn
- □ Nausea
- □ Digestive issues
- □ Constipation
- □ Diarrhea

- □ Urinary Frequency/Urgency
- □ Urinary Tract Infections
- □ Blood in urine (hematuria)
- □ Incontinence

- □ Muscle or joint pain
- □ Stiffness
- □ Sprain/Strain
- □ Redness/Swelling of joints
- □ Arthritis
- □ Scoliosis

- □ Skin Rashes
- □ Hair and nail changes

- □ Dizziness
- □ Fainting
- □ Seizures
- □ Numbness/Tingling

- □ Nervousness
- □ Depression
- □ Memory loss
- □ Stress

- □ Thyroid Condition
- □ Heat or cold intolerance
- □ Sweating

- □ Ease of bruising
- □ Ease of bleeding

- □ Erectile dysfunction
- □ Prostate Trouble
- □ STD's
- □ Sterility
- □ Vasectomy
- □ Frequent Yeast infections
- □ Menopause
- □ Painful/Irregular Menstrual Cycle
- □ Hysterectomy

- □ Leg cramping
- □ Varicose Veins
- □ Coldness in Extremities
- □ Blood clots (thrombus)

- □ Other: _____

Patient Signature: _____ **Date:** _____