



12445 E. 12 Mile Rd.  
Warren, MI 48093  
Phone: (586) 573-6622

**CONFIDENTIAL PATIENT HEALTH RECORD  
PERSONAL HISTORY**

Date: \_\_\_\_\_

Name (Last, First): \_\_\_\_\_ Social Security #: \_\_\_\_\_

Sex:  Male /  Female Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status:  Single  Married  Engaged  Significant Other  Divorced  Separated  Widowed

Name/Ages of Children \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact Name & Phone  
\_\_\_\_\_

**EMPLOYMENT & INSURANCE INFORMATION**

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Type of Work \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Contract #: \_\_\_\_\_ Group # \_\_\_\_\_

Subscribers Name \_\_\_\_\_ S.S. # \_\_\_\_\_ D.O.B \_\_\_\_\_

Subscribers Employer \_\_\_\_\_ Subscribers Work Phone \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Contract #: \_\_\_\_\_ Group # \_\_\_\_\_

Subscribers Name \_\_\_\_\_ S.S. # \_\_\_\_\_ D.O.B \_\_\_\_\_

Subscribers Employer \_\_\_\_\_ Subscribers Work Phone \_\_\_\_\_

Who is responsible for your bill?  You  Spouse  Auto Insurance  Workers' Comp  Medicare  Other

**REFERRED BY** \_\_\_\_\_

**CURRENT HEALTH HISTORY**

Chief Complaint \_\_\_\_\_

Date condition began: \_\_\_\_\_ Have you had this condition before?  YES  NO When? \_\_\_\_\_

Name of Doctors seen for this condition \_\_\_\_\_

Treatment/Result \_\_\_\_\_

Is the condition:  Job Related  Auto Accident  Home Injury  Fall  Other (specify) \_\_\_\_\_

Have you reported this accident to:  Employer  Auto Insurance  Police  Lawyer

Do you suffer from any condition other than that for which you are consulting us? \_\_\_\_\_

Current Medications:  
\_\_\_\_\_  
\_\_\_\_\_

**PAST HEALTH HISTORY  
Surgeries**

Appendectomy  Broken Bone  Back Surgery  Gall Bladder  Hernia  Heart  Tonsillectomy  Vascular

Other \_\_\_\_\_ Details and Year \_\_\_\_\_

**ACCIDENTS** \_\_\_\_\_

**HOSPITALIZATIONS** \_\_\_\_\_

**CHIROPRACTIC CARE HISTORY**

None or Doctors Name & Date of Last Visit \_\_\_\_\_

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD**

- Anemia  Diabetes  H.I.V.+  Lumbalgia  Pleurisy  Rubella  
 Arthritis  Eczema  Hypertension  Measles  Pneumonia  Tuberculosis  
 Cancer  Epilepsy  Hypertension  Mental Disorders  Polio  Whooping Cough  
 Chicken Pox  Heart Disease  Influenza  Mumps  Rheumatic Fever  
Other  \_\_\_\_\_

**CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE LAST 6 MONTHS:  
NERVOUS SYSTEM**

- Anxiety  Cold/Tingling Arms  Depression  Nervousness  Stress  
 Confusion  Cold/Tingling Feet  Fainting  Numbness  Other \_\_\_\_\_  
 Convulsions  Dizziness  Forgetfulness  Paralysis  Headaches

**MUSCULO-SKELETAL** \_\_\_\_\_

- Arm Pain R / L  Low back problems  Neck Pain  Jaw Pain/Clicking  Leg Pain/Numbness  
 Disc (Bulge/Herniation)  Mid back problems  Shoulders (Pain between)  Walking (Difficulty)  Other \_\_\_\_\_

**EYE, EARS, NOSE & THROAT** \_\_\_\_\_

- Ear Aches/Infections  Hearing Problems  Sore Throat  Strep Throat  Vision Problems  
 Dental Problems  Menieres Disease  Stuffy Nose  Vertigo  Other \_\_\_\_\_

**CARDIO- VASCULAR / RESPIRATORY** \_\_\_\_\_

- Ankle Swelling  Carotid Arteries  Heart Murmur  Lung Congestion  Varicose Veins  
 Abdominal Aorta  Chest Pain  Irregular Heartbeat  Shortness Breath  \_\_\_\_\_  
 Blood Pressure (High / Low)  Heart Problems  Lung Problems  Stroke  \_\_\_\_\_

**GASTRO-INTESTINAL** \_\_\_\_\_

- Abdominal Cramps  Black Bloody Stool  General Stiffness  Heartburn  Vomiting (Frequent)  
 Acid Reflux  Bloating/Gas  Diarrhea  Hemorrhoids  Weight Problems  Appetite Decrease/Increase  Colitis  Excessive Thirst  
 Liver Problems  Constipation  Gall Bladder  Nausea (Frequent)  Other \_\_\_\_\_

**GENITO-URINARY** \_\_\_\_\_

- Bladder Trouble  Menstrual Cramps  Prostate  Sexual Dysfunction  Urination-Excessive  
 Breast Pain/Lumps  Menstrual Irregularity  Urine Discoloration  Urination-Painful  Vaginal Pain/Infection

**GENERAL** \_\_\_\_\_

- Allergies  Fatigue  Fever  Headaches  Insomnia  Other \_\_\_\_\_

**FEMALES ONLY**

Date of last menstrual period \_\_\_\_\_ Are you pregnant? YES / NO / NOT SURE

**DO NOT WRITE BELOW THIS LINE**

Doctors Notes: Examining Doctors Signature: \_\_\_\_\_