Spinal Recovery Center
2243 E. 12 Mile Road Warren, MI 48092
Phone: 586-573-8100 Fax: 586-573-8101

Confidential Patient Information Date_____

Last Name _____ First Name_____ Middle Initial__ S.S. # _____

Address_____City_____ State_____ Zip_____

Home Phone _____ Cell Phone_____ D.O.B._____

E-Mail Address_____ Marital Status: M S W D

Race:_____ Ethnicity:_____ Preferred Language:_____

Occupation_____ Employer_____ Work Phone_____

Employers Address_____

Name of Insurance Company_____ Insurance I.D. #_____

Insured's name if patient is a dependent_____ Relationship to patient_____

Name of Husband or Wife_____ Occupation_____

Emergency Contact_____ Phone Number_____

May we contact this person to reach you?

Is condition due to injury or sickness arising out of the patient's employment? _____

Date symptoms or accident happened _____

Have you ever had the same or similar conditions? _____ If yes, when and describe_____

Have you lost any days from work? _____ Date of last physical examination? _____

Female: Are you pregnant or think you may be? _____ If so, how far along?_____

What operations have you had and how long ago were they? _____

Serious Illnesses?_____ Fractured bones?_____

Have you ever suffered from the following?:

□ Allergy	□Foot trouble	□Diabetes	□Deafness	□Pain over heart
□Fatigue	□Low back pain	□Difficult digestion	□Venereal Disease	□Poor circulation
□Dizziness	□Neck pain or stiffness	□Hemorrhoids	□Tuberculosis	□Rapid heart beat
□Headache	□Alcoholism	□Nausea	□Bruise easily	□Slow heart beat
□Loss of sleep	□Poor posture	□Asthma	□Hay fever	□Anemia
□Ulcers	□Sciatica	□Colds	□Polio	□Stroke
□Nervousness/Depression		□Spinal curvatures	□Nosebleeds	□Chest pain
□Numbness	□Swollen joints	□Ear noises	□Sinus infection	□Difficulty breathing
□Arthritis	□Colon trouble	□Enlarged thyroid	□High blood pressure	□Pleurisy
□Bursitis	□Diarrhea	□Eye pain	□Low blood pressure	□Excessive menstrual flow

□Spitting	□Kidney infection/stone	Numbness or tingling in:
□Swelling of ankles	□Prostate trouble	□Shoulders □Hips
□Cancer	□Cramps/backache	□Arms □Legs
□Itching	□Hot flashes	□Elbows □Knees
□Varicose veins	□Irregular cycle	□Hands □Feet
□Bed wetting	□Lumps in breast	
□Frequent urination		

Habits:	Heavy	Moderate	Light	None
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Appetite	□	□	□	□

Do you:

Take vitamins or minerals currently? □Yes □No
Think you may need vitamins or minerals? □Yes□No
Take fish oils currently? □Yes □No
Are you wearing: Heal lifts ____ Sole lifts___

Have you ever been under chiropractic care?_____ Doctor's name and how long ago?_____

What aggravates your condition?_____

Is this condition getting progressively worse? □Yes □No □Constant □Comes and goes □Other_____

Is this condition interfering with your: □Work □Sleep □Daily Routine □Other_____

How long has it been since you've felt really good?_____

What do you believe is wrong with you?_____

Other doctors seen for this condition:_____

Have you been treated by a physician for any health conditions in the past year? If so, please describe_____

What medications are you currently taking?_____

Family doctors name_____ Address_____

Send a report? □Yes □No

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this healthcare clinic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this healthcare clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will immediately due and payable.

Patient Signature_____ Date Signed_____