

Welcome To

Precise Chiropractic

4101 John R. Rd Suite 300 • Troy, MI 48085 • (248) 680-7200

Name _____ Date _____

Last

First

Middle Initial

Choose One: Minor Married Divorced Separated Widowed Single Do you have Medicare? Yes No

Address _____ City _____ State _____ Zip _____

Phone _____ Cell _____ Work _____ Email _____

Date of Birth _____ Age _____ Sex _____ **Whom may we thank for your referral?** _____

Occupation _____ Employer's Name & Address _____

Ht. _____ ft. _____ in. Weight _____ Spouse/Guardian _____ Spouse's Employer _____

Children's Names and Ages _____

List your major complaints in order of severity and please indicate how long you have had this complaint.

1. _____

2. _____

3. _____

DO YOU HAVE ANY DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, MARK "X"

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting or seizures | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Painful Menstruation |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Ringing of ears | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Irregular Menstruation |
| <input type="checkbox"/> Loss of smell-taste | <input type="checkbox"/> Hearing difficulty | <input type="checkbox"/> Anemia | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Hayfever/ Allergies | <input type="checkbox"/> Eye/ vision trouble | <input type="checkbox"/> Acid reflux or ulcers | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Neck muscle spasm | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Tailbone/sacrum pain |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tightness in shoulder muscles | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Throat trouble | <input type="checkbox"/> Pain in shoulders & arms | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Infections | <input type="checkbox"/> Pins & needles in arms & hands | <input type="checkbox"/> Nerves, nervousness | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Inner tension | <input type="checkbox"/> Slipped disc |
| <input type="checkbox"/> Sleeping trouble | <input type="checkbox"/> Chest pains or rib pains | <input type="checkbox"/> Irritability-moodiness | <input type="checkbox"/> Pinched nerve in back |
| <input type="checkbox"/> Facial pain or palsy | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Pins & needles in legs |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Depression/ anxiety | <input type="checkbox"/> Heart palpitation or heart trouble | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Numbness in legs |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Buttocks pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Dizziness/ vertigo | <input type="checkbox"/> Mid back or shoulder pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Groin pain |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Constipation | <input type="checkbox"/> Pain in legs and feet |

List any **accidents or injuries** in the past year: _____

List any injuries between 1 and 10 years: _____

List any injuries over 10 years: _____

List all **surgeries or fractures** and when: _____

List all **medications** and what they're for: _____

Other doctors seen for this condition: _____

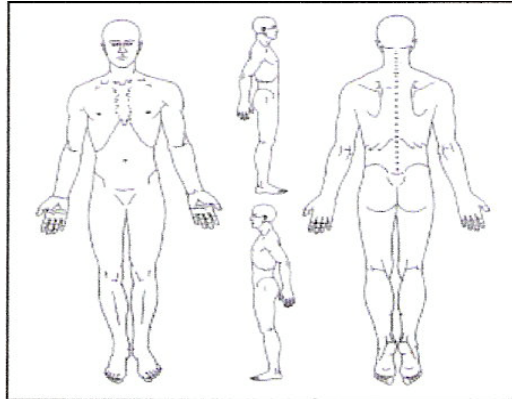
Previous chiropractic care? Yes No When? _____

What are your expectations from receiving and maintaining your spinal correction at Precise Chiropractic?

PLEASE TURN OVER →

Are you willing to be an active patient in the improvement of your health? _____

Please mark where there is discomfort



As a result of my chiropractic care, I would like to

Please check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Feel better quickly | <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Live a healthier lifestyle |

Signature

Date