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_____Cell Carrier_____ OK to receive text messages? ❑Yes ❑ No

Email_____OK to receive email messages? ❑Yes ❑No 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 Birthday _____

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"

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

List all auto accidents you have been in:_____

List any concussions you have had in your life:_____

List any time you were knocked unconscious in your life:_____

List any stitches you received not related to a surgery:_____

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

List any additional injuries between 1 and 10 years: _____

List any additional injuries over 10 years: _____

PLEASE TURN OVER →

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

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

Other doctors seen for this condition: _____

Do you wear orthodics? ❑ Yes ❑ No Do you wear a heel lift? ❑ Yes ❑ No ❑ Right ❑ Left How long?_____

Previous chiropractic care? ❑ Yes ❑ No When? _____

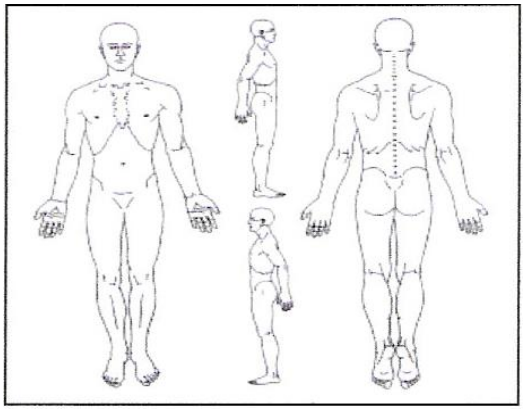
What are your expectations from receiving and maintaining your spinal correction at Precise Chiropractic?

_____

_____

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

- ❑ Feel better quickly
- ❑ Have a healthier spine
- ❑ Have a healthier body by keeping my nerve system healthy
- ❑ Live a healthier lifestyle

What are your top 3 health goals?

1. _____
2. _____
3. _____

_____ _____

Signature Date

_____ _____

Doctor's signature Date