

Dobson Chiropractic Center

102 W Clinton St. Durand MI, 48429
989-288-5351

139 S Saginaw St. Chesaning, MI 48416
989-845-5433

GENERAL INFORMATION

First Name _____ M.I. ____ Last Name _____ D.O.B. ____/____/____

Address _____ City _____ State _____ Zip _____ S.S.N. ____-____-____

Phone (home) ____-____-____ # Of Children and Their Ages _____

Phone (cell) ____-____-____ Name Of Children _____

Phone (work) ____-____-____ E-Mail Address _____

Sex _____ Status M ___ S ___ W ___ D ___

Spouse's Name _____ Spouse's Employer _____

Name and Number of Emergency Contact _____ - ____ - ____

Is this appointment for you or your entire family? _____

Referred by: _____

What is your reason for consulting our office?

___ Wellness care plan to maintain optimum health

___ Help with a specific problem _____

INSURANCE INFORMATION

Patient's Employer Name _____

Address _____ City _____ St _____ Zip _____

Phone _____ Occupation _____

Employed Full Time _____ Part-Time _____ Retired _____ Not Employed _____

Student Full Time _____ Part-Time _____

Primary Insurance _____

Insured's Name _____ Insured's D.O.B. _____

Patients Relationship to Insured _____ Insured's Employer _____

Secondary Insurance

Insured's Name _____ Insured's D.O.B. _____

Patients Relationship to Insured _____ Insured's Employer _____

Check if you have had any of these symptoms in the last 12

months:

<input type="checkbox"/> Fractured Bone Auto Accidents <input type="checkbox"/> 0-1yrs <input type="checkbox"/> 1-5 yrs <input type="checkbox"/> 5 or more yrs <input type="checkbox"/> Other accidents, falls <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Convulsions <input type="checkbox"/> Skin Problems <input type="checkbox"/> Cancer <input type="checkbox"/> Frequent colds, flu <input type="checkbox"/> Depressed <input type="checkbox"/> Irritable <input type="checkbox"/> Anemia <input type="checkbox"/> Allergy, sinus <input type="checkbox"/> Stress <input type="checkbox"/> Eating disorders <input type="checkbox"/> Trouble concentrating <input type="checkbox"/> Trouble sleeping <input type="checkbox"/> Headaches <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Learning disability <input type="checkbox"/> Mood Changes <input type="checkbox"/> Neck/stiffness <input type="checkbox"/> Numbness, tingling, pain in arms, hands, fingers (circle) R L <input type="checkbox"/> Jaw pain or click (TMJ) R L <input type="checkbox"/> Difficulty in excessive standing, sitting, riding, bending, lifting, or twisting (circle) R L <input type="checkbox"/> Shoulder pain R L <input type="checkbox"/> Dizziness <input type="checkbox"/> Ringing in Ears R L <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Blurred vision or double vision <input type="checkbox"/> Upper back pain, stiffness <input type="checkbox"/> Mid back pain <input type="checkbox"/> Lower back pain <input type="checkbox"/> Pain with cough, sneeze <input type="checkbox"/> Hip Pain R L	<input type="checkbox"/> Numbness, tingling, pain in buttox, legs, feet, toes (circle) R L <input type="checkbox"/> Foot trouble <input type="checkbox"/> Chest pain, asthma <input type="checkbox"/> Heart problems <input type="checkbox"/> Stroke <input type="checkbox"/> High/Low blood pressure <input type="checkbox"/> Varicose veins <input type="checkbox"/> Liver trouble <input type="checkbox"/> Gall bladder <input type="checkbox"/> Digestive problems <input type="checkbox"/> Ulcers <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Prostate problems <input type="checkbox"/> Impotence <input type="checkbox"/> Kidney trouble <input type="checkbox"/> Menstrual Problems, PMS <input type="checkbox"/> Pregnant (now) <input type="checkbox"/> Bedwetting <input type="checkbox"/> Ear infections
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CURRENT HEALTH CONDITION

Unwanted health condition: _____

When did this begin? _____

Had this condition occurred before? Yes ___ No ___

When? _____

Is condition: Job Related ___ Auto Accident ___ Home Injury ___ Fall ___ Other: _____

Date of Accident: _____ Time of Accident: _____

If work related have you made a report of your accident to your employer? ___ Yes ___ No

PAST HEALTH HISTORY

Please check and describe: Major surgery/operations: Appendectomy ___ Tonsillectomy ___

Gall Bladder ___ Hernia ___ Back Surgery ___ Broken Bones ___

Other _____

Major Accidents or Falls: _____

Hospitalization (other than above): _____

Do You Want Relief Care or Corrective Care?

Relief care helps to get rid of your symptoms, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective care differs from relief care in that its goal is to get rid of the pain and the underlying problem. Corrective care varies in length of time, but it is more lasting and greatly improves your overall health.

Check One

Relief Care: ___ Corrective Care: ___

Wellness Commitment

Dobson Chiropractic Center we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not ask for a financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness.

10% → 20% → 30% → 40% → 50% → 60% → 70% → 80% → 90% → 100%

Chiropractic History

Have you been to a chiropractor before? _____ Last adjustment ____/____/____

If yes, doctor's name _____ Reason for care _____

What are your health goals? _____

List any current medications: _____

Do you have a secondary problem, such as: Sinus problems, asthma, diabetes, digestive trouble, arthritis, fatigue, mood swings, trouble sleeping or any other problem you would like to get rid of?

Regarding this problem, how long? _____ How often? _____

Before you noticed these problems, were there any earlier accidents, injuries, physical stress, sports or falls that may have injured your spine or nervous system? (Ex:auto, falls, work injuries, repetitive motion, on the job, sitting at a computer for hours, etc.) _____

Since the time you first had these problems, what, if anything, have you tried to do to get rid of them that did not work permanently? (ex. Ice, heat, over the counter medication, prescriptions, other)

When your problems are at their worst, describe what happens (For example: Do you get nauseous, irritable, restricted in motion, have to lay down, etc?) _____

Does your health problems make it harder to do your job? _____ In what way? _____

Have you had to take more breaks? ___Yes ___No

Are you less productive due to your health problems? ___Yes ___No

When your problems are at their worst, they can affect your relationships with family and friends. ___Yes ___No

Do you help less around the house? ___Yes ___No

Are there things you aren't able to do? _____

What hobbies or interests do you have? _____

When your problems are at their worst, have they ever prevented you from doing or enjoying your hobby? _Y _N

Is there anything you'd do more if you didn't have these problems? _____

Do you have:

Trouble falling asleep due to being uncomfortable? ___Yes ___No

Are you getting enough restful sleep? ___Yes ___No

Do your problems wake you up earlier than normal? ___Yes ___No

Assuming that the doctor looks at your x-rays, and he can help your problem, is there anything that would prevent you from following through with our treatment program such as time, transportation, or other. ___Yes ___ No
Specify:_____

On a scale of 1-10, with 10 being the highest in getting rid of your problems, how much do you want to get rid of these problems and feel great?_____

Dobson Chiropractic Center

This notice is effective as of ___/___/____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the records were created. My signature acknowledges that I have received a copy of this notice.

_____	_____	___/___/___
Printed Name	Signature	Date
_____	_____	___/___/___
Personal Representative Printed	Signature	Date

Description of the authority to act on behalf of the patient

Notice of Privacy Practices

Any information given to this office is confidential. This information will be used for treatment of patients. Information will also be used for insurance billing when applicable. Any other use of this information will be only with written or spoken consent of patient. Names and addresses will be used only for mailing by this office. No mailing lists will be sold.

Release and Assignment

I authorize release of any information necessary to process my insurance claim and assign and request payment directly to my physicians.

_____	_____	___/___/___
Printed Name	Signature	Date

Financial Responsibility

I agree to be financially responsible for all charges incurred at this clinic, including my insurance deductible, co-payment, and any other services rejected or not covered by my insurance.

_____	_____	___/___/___
Printed Name	Signature	Date

Dobson Chiropractic Center

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes the alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuromusculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another healthcare provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature

____/____/____
Date

Consent to evaluate and adjust a minor child:

I _____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ____/____/____

Signature

____/____/____
Date

