"Well-Adjusted" Chiropractic & Massage

1121 N. Saginaw Street, Suite 2
Holly, MI 48442
(248) 328-9291

Patient and Insurance Information

Name Date

Address Apt #

City State ZIP

Home Phone Work Phone Cell Phone

Gender M F Birth Date Age Soc Sec #

Email Address Referred By

Marital Status M S D W Sep # of Children Age Range of Children

Spouse Name

Emergency Contact Phone # Relationship

Employer Occupation

Address

City State ZIP

Responsible Party / Insurance Information

Primary Insurance Ins Co Phone

Address

Policy # Group #

Patient Relationship to the insured Self Spouse Child Other

If you have a Secondary insurance…. Please complete below

Relationship to the insured Self Spouse Child Other

Name of Policy Holder Soc Sec #

Address

Phone Gender M F Birth date

Policy Holder's Employer

Address

Employer Phone Plan Name

For our Records Please select appropriate condition if it applies :

_____Personal Injury _____ Auto Accident _____ Workers Compensation

I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at *Well Adjusted Chiropractic,* responsible for any errors or omissions that I may have made in completion of this form.

By Signing below, I authorize consent to *Well Adjusted Chiropractic* to provide medical care and treatment.

Print Name: _____

Signature:_____ Date: _____

Name:_____ Date:_____

"Well-Adjusted" Chiropractic & Massage

*Mark All that apply

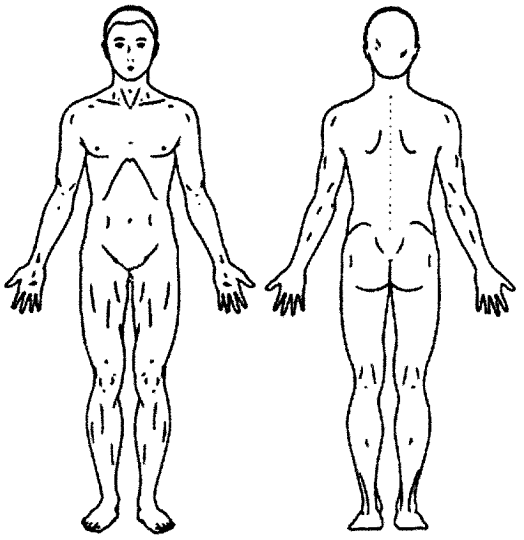
What is the reason for your visit today? ___ Headache ___ Neck Pain ___ Mid-Back Pain ___Low-Back Pain ___ Other (explain)

What caused this complaint? ___An Accident ___A Trauma ___A Work Injury ___An Auto Accident ____An Illness ___ An aggravation of a congenital problem ____ Unknown Factors ____ Other Explain_____

When did this complaint begin?_____ How Long Does the pain last? _____

Have you had this or a similar complaint in the past? ___ Yes ___ No
If "Yes" When: _____ How many times has this occurred?_____

Mark an "X" on the body diagram where you have pain or other symptoms.



Primary Complaint: _____
Circle Severity/ Intensity of Pain:
No Pain Moderate Agonizing
0 1 2 3 4 5 6 7 8 9 10
Is the pain or symptoms getting worse? ___ Yes ____No
___Constant ___Comes & Goes

Secondary Complaint: _____
Circle Severity/ Intensity of Pain:
No Pain Moderate Agonizing
0 1 2 3 4 5 6 7 8 9 10
Is the pain or symptoms getting worse? ___ Yes ____No
___Constant ___Comes & Goes

Additional Complaint: _____
Circle Severity/ Intensity of Pain:
No Pain Moderate Agonizing
0 1 2 3 4 5 6 7 8 9 10
Is the pain or symptoms getting worse? ___ Yes ____No
___Constant ___Comes & Goes

What do your Symptoms Feel like? (Mark All That Apply) ___Crawling ___ Dead ___ Numb ___Pins/Needles ___Prickling ___Tingling ___ Achy ___Burning ___Dull ___Excruciating ___Numb/Ache Type ___Pounding ___Pulsating ___Sharp ___Shooting ___Stabbing ___Throbbing ___Sore ___Stiffness ___Electric Shock ___Tightness

Are your symptoms worse: ___In the Morning ___Afternoon ___As the Day progresses ___Evening ___While Sleeping ___During Activities ___After Activities OR ___Symptoms are constant and not changing.
___ Other _____
What area(s) of your body does your pain radiate, shoot or travel to (if applicable)? _____

What aggravates this complaint? ___Coughing ___Sneezing ___Straining at BM ___Bending ___Carrying ___Climbing a ladder ___Climbing stairs ___Driving ___Looking down ___Looking up ___Reclining ___Repetitious movements ____Sleeping ____Turning head to Left ___Turning head to Right ___Driving ___Emotional upset ___Stress ___Exercising ___Getting in & out of a car ___Getting out of bed ___Lifting ___Pulling ___Pushing ___Sitting ___Stooping ___Standing ___Walking ___Walking uphill ___Shoveling Snow ___Raking leaves ___Snowmobiling

Have you had any previous care or seen any other provider(s) for this problem? ___Yes ___ No If 'Yes', Please provide
Doctors Name: _____ **Date consulted**: _____

(*Office Use Only*) Notes:

Name:_____ Date:_____

Personal Health History

Are your currently under the care of a Healthcare Provider or any other doctor? ___Yes ___No
If yes, for what condition(s)_____

Provider's Name _____ Phone Number_____

Please Indicate All past and present Medical Health Problems for Self (*S*) and/or Family (*F*) OR
___ None, *I am In Good Health.*

___Diabetes	___Stomach Problems	___Ulcer Disease	___Kidney Disease
___Mitral Valve Prolapse	___High Cholesterol	___Lung Disease	___Heart Problems
___Liver Problems	___Asthma	___Bleed easily	___Arthritis
___Stroke	___Other (Please specify)_____		

Please list any Medications / Supplements you are currently taking: _____

_____*I will provide a list.*
Please list any/all Past Surgeries and provide Date: ____ NONE

Indicate any past Injuries: (List date next to injury)
_____back injury _____fracture _____laceration (severe) _____broken bones _____head injury
_____disability(ies) _____Industrial accident _____soft tissue injury _____fall (severe)
_____joint injury _____motor vehicle accident _____Other

Family History

Mother: ___Alive ___ Deceased *Cause of Death* ___ Natural ___ Illness
Age____ Illness_____
Father: ___Alive ___ Deceased *Cause of Death* ___ Natural ___ Illness
Age____ Illness_____
Sibling(s): ___Alive ___ Deceased *Cause of Death* ___ Natural ___ Illness
Age____ Illness_____
___Alive ___ Deceased *Cause of Death* ___ Natural ___ Illness
Age____ Illness_____

Any other Known Hereditary Issues? _____

Social History

Highest Level of Education: ___Not Completed High School ____GED or Equivalent ___H. S Graduate ___An Associates ___A Bachelors ___Trade School ___A Masters ___A PHD ___Completed Law School ___Completed Medical School ___ Doctorate Program (Other than Medical)

Do you eat a Well-Balanced Diet? ___Never ___Rarely ___Occasionally ___Usually ___Regularly

Do you Exercise? ___Never ___Rarely ___Occasionally ___Usually ___Regularly

Types of exercise: ___Run / Jog ___Walk ___Weight Lifting ___Yoga/Pilates ___Group Exercise ___Baseball ___Basketball ___Football ___Golf ___Soccer ___Tennis ___Swimming

Do you Drink Alcohol? ___ Yes ___ No How many years? _____ ____Formerly
___ Never ___ Occasionally ___Frequently (3 days/week or more) ___Daily

Do you Use Tobacco Products? ___ Yes ___ No How many years? _____ ____Formerly
___ Never ___ Occasionally ___Frequently (3 days/week or more) ___Daily

Name:_____ Date:_____

Review of Systems

1. General:
___No Symptoms
___Decreased Activity level
___Fever
___Chills
___Fatigue
___Night Sweats
___Loss of Appetite
___Weight gain
___Weight loss
___Loss of energy
___Uncontrolled sweating

2. Psychological:
___ No Symptoms
___Irritability
___Depression
___Disturbed sleep
___Suicidal Thoughts
___Anxiety
___ Nervousness

3. Urination
___No Symptoms
___Frequent Urination
___Urgency
___Trouble stopping or starting stream
___Nocturia
___Erectile Dysfunction
___Burning with urination
___Hesitancy
___Losing Control / Incontinence
___Bowel dysfunction
___Sexual Dysfunction

4. Eyes / Vision
___No Symptoms
___Blurred Vision
___Double Vision
___Vision Loss
___Eye Pain
___Work Glasses / Contacts

5. Cardiovascular
___No Symptoms
___Chest Pain
___Palpitations
___ Fainting
___Shortness of Breath
___Ankle Swelling

6. Breathing
___No Symptoms
___Coughing
___Wheezing
___Shortness of Breath

7. Stomach
___No Symptoms
___Nausea
___Vomiting
___Diarrhea
___Constipation
___Loss of Bowel Control

8. Muscle /Joint
___No Symptoms
___Joint Pain
___Joint Weakness
___Muscle Weakness

9. Skin
___No Symptoms
___Rash
___Itching
___Dryness
___Lesions
___Open Wound/ Infection
___Hair / Nail changes

10. Immunity
___No Symptoms
___Enlarged Lymph nodes
___Hives
___Hay Fever
___Persistent Infections

11. Endocrine
___No Symptoms
___Diabetes
___Thyroid Disorder

12. Neurological
___No Symptoms
___Seizures
___Abnormal Sensory Feelings in Extremity
___Loss of Memory

13. Bleeding / Bruising
___No Symptoms
___History of Anemia
___Abnormal Bleeding
___Bruising
___Heat Intolerance
___Cold Intolerance

Name:_____ Date:_____

Oswestry Back Index

This questionnaire will give your provider information about how your back condition affects your everyday life.
Please answer every section by marking the one statement that applies to your BACK right now.

1. Pain Intensity **0.** The pain comes and goes and is very mild. **2.** The pain is mild and does not vary much. **4.** The pain comes and goes and is moderate. **6.** The pain is moderate and does not vary much. **8.** The pain comes and goes and is very severe. **10.** The pain is very severe and does not vary much.	**6. Standing** **0.** I can stand as long as I want without pain. **2.** I have some pain while standing but it does not increase with time. **4.** I cannot stand for longer than 1 hour without increasing pain **6.** I cannot stand for longer than 1/2 hour without increasing pain. **8.** I cannot stand longer than 10 minutes without increasing pain. **10.** I avoid standing because it increases pain immediately.
2. Personal Care **0.** I do not change my habits in order to avoid pain. **2.** I do not change my habits even though it causes some pain. **4.** My personal care habits increases the pain but I manage not to change my habits. **6.** My personal care habits increases the pain and I find it necessary to change my way of doing it. **8.** Because of the pain I am unable to do some personal care without help. **10.** I am unable to do any dressing or washing without help.	**7. Sleeping** **0.** I get no pain in bed. **2.** I get pain in bed but it does not prevent me from sleeping well. **4.** Because of pain my normal sleep is reduced by less than 25%. **6.** Because of pain my normal sleep is reduced by less than 50%. **8.** Because of pain my normal sleep is reduced by less than 75%. **10.** Pain prevents me from sleeping at all.
3. Lifting **0.** I can lift heavy weights without extra pain. **2.** I can lift heavy weights but it causes extra pain. **4.** Pain prevents me from lifting heavy weights off the floor. **6.** Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table). **8.** Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned. **10.** I can only lift very light weights.	**8. Traveling** **0.** I get no pain while traveling. **2.** I get some pain while traveling, does not make it worse. **4.** I get extra pain while traveling but I do not change my form of travel. **6.** I get extra pain while traveling which causes me to seek alternate forms of travel. **8.** Pain restricts all forms of travel. **10.** Pain restricts all travel except that done while lying down.
4. Walking **0.** I have no pain while walking. **2.** I cannot walk more than 1 mile without increasing pain. **4.** I cannot walk more than 1/2 mile without increasing pain. **6.** I cannot walk more than 1/4 mile without increasing pain **8.** I have increased pain and can only walk with crutches or assistance. **10.** I cannot walk at all without increasing pain (Bedridden and must crawl).	**9.Social Life** **0.** My social life is normal and gives me no extra pain. **2.** My social life is normal but increases the degree of pain. **4.** Pain has no significant affect on my social life but does limit my more energetic interests (e.g., dancing, etc). **6.** Pain has restricted my social life and I do not go out very often. **8.** Pain has restricted my social life to my home. **10.** I have hardly any social life because of the pain.
5. Sitting **0.** I can sit in any chair as long as I like. **2.** I can only sit in my favorite chair as long as I like. **4.** Pain prevents me from sitting more than 1 hour. **6.** Pain prevents me from sitting more than 1/2 hour. **8.** Pain prevents me from sitting more than 10 minutes. **10.** I avoid sitting because it increases pain immediately.	**10.Changing degree of pain** **0.** My pain is rapidly getting better. **2.** My pain fluctuates but overall is definitely getting better. **4.** My pain seems to be getting better but improvement is slow. **6.** My pain is neither getting better or worse. **8.** My pain is gradually worsening. **10.** My pain is rapidly worsening.

Name:_____ Date:_____

Neck Index

This questionnaire will give your provider information about how your Neck condition affects your everyday life.
Please answer every section by marking the one statement that applies to you right now.

1. Pain Intensity **1.** I have no pain at the moment **2.** The pain is mild at the moment. **4.** The pain comes and goes and is moderate. **6.** The pain is moderate and does not vary much. **8.** The pain is severe but comes and goes. **10.** The pain is severe and does not vary much.	**6. Concentration** **1.** I can concentrate fully with no difficulty. **2.** I can concentrate with slight difficulty. **4.** I have a fair degree of difficulty in concentrating. **6.** I have a lot of difficulty in concentrating. **8.** I have a great deal of difficulty in concentrating. **10.** I cannot concentrate at all.
2. Personal Care (Washing, Dressing etc.) **1.** I can look after myself without causing extra pain. **2.** I can look after myself normally but it causes extra pain. **4.** It is painful to look after myself and I am slow and careful. **6.** I need some help,but manage most of my personal care. **8.** I need help every day in most aspects of self-care. **10.** I do not get dressed; I wash with difficulty and stay in bed.	**7. Work** **1.** I can do as much work as I want to. **2.** I can only do my usual work, but no more. **4.** I can do most of my usual work, but no more. **6.** I cannot do my usual work. **8.** I can hardly do any work at all. **10.** I cannot do any work at all.
3. Lifting **1.** I can lift heavy weights without extra pain. **2.** I can lift heavy weights, but it causes extra pain. **4.** Pain prevents me from lifting heavy weights off the floor but I can if they are on a table. **6.** Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are on a table. **8.** I can only lift very light weights. **10.** I cannot lift or carry anything at all.	**8. Driving** **1.** I can drive my car without neck pain. **2.** I can drive but have slight pain in my neck. **4.** I can drive but have moderate pain in my neck. **6.** I cannot drive long due to moderate pain in my neck. **8.** I can hardly drive at all due to severe pain in my neck. **10.** I cannot drive my car at all.
4. Reading **1.** I can read as much as I want with no neck pain. **2.** I can read as much as I want with slight neck pain. **4.** I can read as much as I want with moderate pain. **6.** I cannot read as much because of moderate pain in my neck. **8.** I cannot read as much because of severe pain in my neck. **10.** I cannot read at all.	**9. Sleeping** **1.** I have no trouble sleeping **2.** My sleep is slightly disturbed (less than 1 hour sleepless). **4.** My sleep is mildly disturbed (1-2 hours sleepless). **6.** My sleep is moderately disturbed (2-3 hours sleepless). **8.** My sleep is greatly disturbed (3-5 hours sleepless). **10.** My sleep is completely disturbed (5-7 hours sleepless).
5. Headache **1.** I have no headaches at all. **2.** I have slight headaches which come infrequently. **4.** I have moderate headaches which come in-frequently. **6.** I have moderate headaches which come frequently. **8.** I have severe headaches which come frequently. **10.** I have headaches almost all the time.	**10. Recreation** **1.** I am able to engage in all recreational activities with no pain. **2.** I am able to engage in all recreational activities with some pain. **4.** I am able to engage in most, but not all recreational activities because of pain in my neck. **6.** I am only able to engage in a few of my usual recreational activities because of pain in my neck. **8.** I can hardly do any recreational activities because of neck pain. **10.** I cannot do any recreational activities all.

Please answer every section by marking the one statement that applies to your NECK right now.

Name:_____ Date:_____

Authorization, Assignment & Release

Please Read this entire document prior to signing it. It is important you understand the information contained in this document. Please ask questions before you sign if anything is unclear.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I_____ acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Well Adjusted Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____Date_____Signature_____Print Name

Consent for Medical Treatment of a Minor

I _____ (Parent/Guardian) authorize Well Adjusted Chiropractic to administer Chiropractic care as deemed necessary to my minor child _____*(minor patient).*

My Minor child is authorized to receive Chiropractic treatment when brought by a Relative or Friend.

_____(Name & Relationship)

* Authorized person(s) must be 18 or older. Parent/Guardian Must be present for any New Patient Exams, Re-Exams and Report of Findings.

Print Name: _____ (Parent / Legal Guardian)

Signature:_____ Date: _____

Acceptance Agreement (Please Read & Initial Each statement)

_____***Patient Records:*** Patient records, including X-rays, are the property of *Well Adjusted Chiropractic*. These records are only released with your written permission or as required legally. Patient confidentiality is always maintained.

If Applicable: _____ I realize that an X-Ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual cycle (mm/dd/yyyy):_____

_____***Financial Matters***: Payment is due at the time services are provided unless prior arrangements have been made. All charges will be explained to you prior to any service being performed. I understand that my Insurance carrier may pay less than the medical services/supplies rendered. I agree to be responsible for payment on all medical services/supplies rendered on behalf of myself, or my minor child.

_____***Insurance***: *Well Adjusted Chiropractic* will accept assignment for most insurance coverage and will be happy to pre-verify your insurance coverage. You will need to provide your insurance card for this process.

_____***Medicare:*** I authorize any holder of medical or other information about me to release to the Social Security Administration and the Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Dr. Shawn DeVary at this office, Well Adjusted Chiropractic.

_____***Medicaid***: *Well Adjusted Chiropractic* will accept assignment for Medicare/Medicaid. Patients are Responsible for their co-payment and payment for any services not covered by Medicare/Medicaid.

_____***Personal Injury***: In most cases, *Well Adjusted Chiropractic* will accept assignment for payment. If *Well Adjusted Chiropractic* accepts assignment for payment the patient is still legally responsible for their account balance. Patients will be required to sign a lien in the case of personal injuries. In this situation, you are asked to authorize direct payment to the clinic through your attorney or the insurance company and permit the endorsement of co-issued checks.

_____***Workers' Compensation***: Work-related injury cases are accepted on assignment with permission of the employer and prior authorization from the employer's compensation insurance carrier.

I have read the above statements and accept these conditions.

Print Name: _____

Signature:_____ **Date:** _____