Pushies Chiropractic Clinic
832 E. Grand River Ave. Williamston, MI 48895 (517) 655-8818

New Patient Intake Form

Name: _____ **Date:** _____

Address: _____**City:**_____ **State:**_____ **Zip:**_____

Home Phone (____)_____**Cell (____)**_____ **Work (____)**_____

Email Address: _____**Male**_____**Female**_____

Birth Date: _____ **Age**_____

Occupation: _____ **Employer Name and Address**_____

Single____ **Married**____ **Spouse's Name** _____

Whom may we thank for referring you to our office? _____

YOUR HEALTH SUMMARY

What is your chief complaint?_____

Have you seen a Chiropractor before? _____ **If yes, when?**_____

Check all symptoms you have ever had even if they do not seem related to your current problem.

___Headaches	___Pins and Needles in legs	___Neck Pain	___Dizziness
___Pins and needles in arms	___Back Pain	___Loss of balance	___Fatigue
___Ringing in ears	___Numbness in fingers	___Numbness in toes	___Cold Feet
___Depression	___Tension	___Menstrual irregularity	___Cold Hands
___Sleeping problems	___Neck Stiffness	___Heartburn	___Vertigo
___Migraines	___Problem Urinating	___TMJD	___Shoulder Pain

Please list any medications you are taking: _____

_____

If this is due to an injury or auto accident, what is the date of injury or accident?_____

Has this problem been getting better, worse, or staying the same?_____

What activities make your condition worse? _____

Any surgeries or hospitalizations?_____

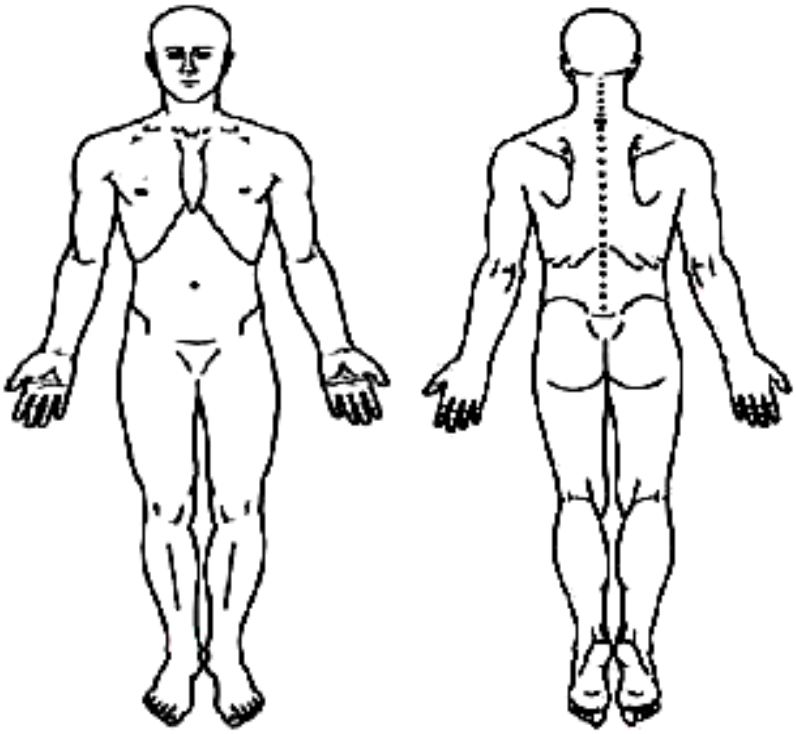
Injuries or illnesses that you have had that are not listed above:_____

Do you have health insurance? □ Yes □ No **Or a HSA account? □ Yes □ No**

If so, please provide the front desk with your card so we can verify your benefits with our office.

If you are in pain, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, *dull, sharp, constant, off and on, when standing, when sitting, etc., etc.*

COMPLETE THESE DIAGRAMS



Method of payment you plan to use for today's charges: ☐ **Check** ☐ **Cash** ☐ **Credit Card**

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE OR VERIFY A DIAGNOSIS, TYPE OF TREATMENT AND LENGTH OF TREATMENT. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. **All first visit charges are payable when services are rendered.**

2. **The fee paid for x-rays is for analysis only. State law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.**

PATIENT AUTHORIZATION REGARDING SIGN-IN SHEETS, TRAVEL CARD USE AND PATIENT RECORD OF DISCLOSURES.

Our office uses sign in sheets, travel cards, and provides care in a semi private adjusting environment. These procedures are done in a private, confidential setting. Your signature below authorizes us to contact you at all phone numbers / addresses you list on this intake form. If you do not wish to be contacted at any listed numbers / addresses, please let us know.

This office conforms to the current HIPAA guidelines

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient's Signature_____**Date**_____