Saunders
Chiropractic Clinic

231 Trowbridge St. Unit #2
Allegan, MI 49010
Phone- 269-512-7077
Fax- 269-512-7078
Email: Saunderschiro@outlook.com

Personal Information

First Name:_____ M.I___ Last Name:_____

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

Date of Birth:____/____/_____ Age:_____ Gender: Male___ Female:_____ Unspecified:_____

Primary Phone: _____ **Cell:** _____ **Work:** _____

Home Email:_____ **Work Email:**_____
(By providing my email addresses, I authorize my doctor to contact me via the emails provided)

Contact Method: (Circle One) Primary Phone, Work Phone, Cell Phone, Home Email, Work Email.

Status: (Circle One) Single Married Divorced Widowed **Children?**: Yes No How many:_____

Race: (Circle One) White Black/African American Hispanic/Latino Asian Native American
Other:_____ Prefer not to Specify

Occupation: _____ **Employer:**_____

Emergency Contact (Name, Relationship, Phone #):_____

How were you referred to Saunders Chiropractic Clinic?: _____

INSURANCE INFORMATION

Type of Insurance (Circle One): Private Insurance Medicare Auto Ins. Workers Comp. Other.

Primary Insurance Carrier: _____ Phone: _____

Policy #:_____**Group #:** _____ **Claim #**:_____

Name of Policy Holder:_____ **Relationship to Patient:**_____

Policy Holder Birthdate: ___/___/____ **Policy Holders SSN:** ____/____/_____ **Employer:**_____

Please continue with insurance on the next page.

INSURANCE INFORMATION CONT.

Is patient covered by another insurance carrier?: YES NO

Secondary Insurance Carrier:_____ **Policy #:**_____

ASSIGNMENT / AUTHORIZATION / RELEASE

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Saunders Chiropractic Clinic of Allegan PLLC, MI all benefits, if any, otherwise paytable to me for services rendered. I authorize the use of my signature on all insurance submission. I understand that "co-pays" are payable at the time of each visit and that I am financially responsible for all charges weather or not they are paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance comapany(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

☐ CASH / PRIVATE PAY: By checking this box, I acknowledge that I DO NOT have insurance and understand that I am financially responsible for all services at the time they are rendered.

Name of person responsible for this account: _____

X_____ **Date:**_____

Signature of Patient, Parent or Legal Guardian (if minor)

PATIENT HEALTH QUESTIONNAIRE

What is the reason for your visit today?: _____

What caused this complaint / condition?: _____

_____

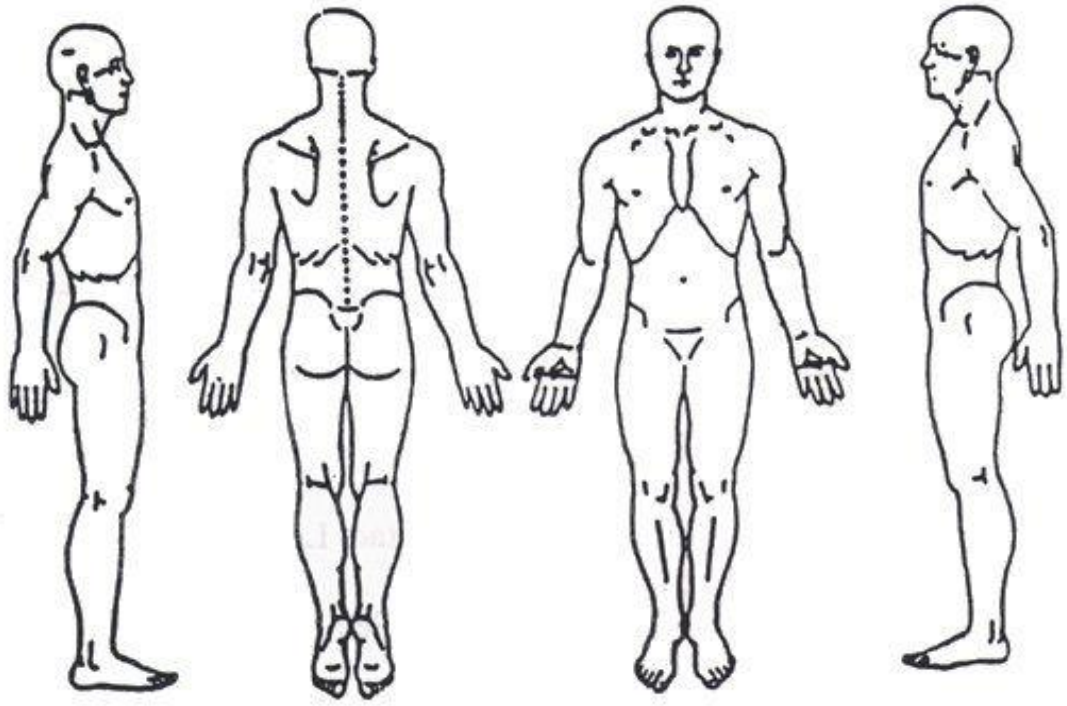
When did this begin?: _____**Is it getting better or worse?:** Better Worse No Change

Have you experienced this in the past? YES NO **If "yes", when?**_____

How would you describe your complaint? (circle all that apply): Sharp / Dull / Sore / Stiff / Tight

Aching / Spasm / Thorbbing / Burning / Stabbing / Shooting / Cramping / Tingling / Numbness

Other: _____



On the body diagram above, Please mark an, "**X**" on the areas that you are experiencing your symptoms.

On the scale below, please circle the corresponding number in regards to your discomfort **0=no pain, 10= Worst**

0 1 2 3 4 5 6 7 8 9 10

HEALTH QUESTIONNARE CONT.

Does your discomfort radiate or travel to any other part of your body?: YES NO

If answer is yes from above, where does the discomfort radiate to?: _____

What activites or positions seem to aggravate your pain / condition?: _____

_____

What seems to help or relieve your symptoms?: _____

_____

How often do you experience your symptoms / discomfort?: _____

Do you experience your symptoms more a certain time of day?: _____

Have you seen any other healthcare professionals for this complaint / condition? YES NO

If you answered, "**YES**" to the question above, please provide the following information.

Profession:_____ **Doctor / Office name:**_____

Date of Consult:_____ **Did it seem to help with complaint?** YES NO

Is your condition interferring with any of the following?: (circle all that apply) Sleep / Recreation

Getting in and out of bed or chair / Lifting / Bending / Walking / Daily Routine / Exercise / Travel

Personal Care / During Activities / After Activities / Other: _____

Does your complaint affect your ability to complete any of your Activities of Daily Living?: YES NO

If, "**YES**" Please describe how.:_____

HEALTH HISTORY

Please Circle **ALL** of the health conditions below that apply to you **Now** or in the **Past**.

Osteoarthritis	Asthma	Diabetes: Type 1 Type 2
Anemia	Cancer / Tumor	Rhuematoid Arthritis
Depression / Anxiety	Herniated Disc	High Blood Pressure / Hypertension
Heart Disease	Stroke	Whiplash Injury
Headaches / Migraines	Shoulder Pain	Elbow Pain
Back Pain	Neck Pain	Hip Pain
Ankle Pain	Knee Pain	Osteoporosis / Osteopenia
Epilepsy / Seizures	Fibromyalgia	Chronic Fatigue

Please provide any other medical conditions you have /experience that are not listed above: _____

_____

Are you currently pregnant?: YES NO N/A If,"YES" when is your due date?_____

Date of last Menstrual Cycle?: _____

Have you ever fractured or broken any bones? YES NO If, "**YES**" please explain:_____

_____

Surgeries and or Hospitalizations (please list and date): _____

_____

Are you currently taking any medications?: YES NO If, "**YES**" please provide information below.

Medication	Dosage	Start Date

FAMILY HISTORY

Please indicate if any of the below conditions run in your family and indicate their relationship to you.

Condition:	**Relationship**:
Cancer	
Diabetes: Type 1 Type 2	
Heart Problems	
Stroke	
Hypertension / High Blood Pressure	
Rheumatoid Arthritis	
Arthritis	
Genetic Disorders	
Other:	

SOCIAL HISTORY

Do you exercise regularly?: YES NO **Times per week?:**_____

Do you smoke?(circle one): YES NO FORMER SMOKER

How often do you smoke (cirlce one)?: Current everday smoker Current occasional smoker

What is your level of interest in quitting smoking?: Not interested Somewhat interested Very interested

Do you drink alcohol (circle one)? YES NO **How many drinks per week?:**_____

Do you consume caffeine (circle one)?: YES NO **How many drinks per day?:** _____

What do your work duties include?:_____

How would you describe your overall health (circle one)?: Excellent Very Good Good Fair Poor

What is your current stress level (circle one)?: Mild Moderate High

Have you seen a chiropractor in the past? YES NO **If,"YES" did it provide relief?:** YES NO

INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign this form if anything is unclear.

The nature of the chiropractic adjustment:
The primary treat I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use this procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joint. This may cause an audible "click" or "pop", much as you have experienced when you "crack" your knuckles. You may notce/feel a sense of movement.

Analysis / Examination / Treatment
As part of the analysis, examination, and treatment, you're consenting to the following procedures:

Spinal Manipulative Therapy	Palpation	Vital Signs
Range of motion testing	Orthopedic testing	Basic Neurological testing
Muscle Strength Testing	Postural Analysis	Hot / Cold Therapy
Radiographic Studies	EMS	Myofascial Therapy
Manual Therapy		

The material risks inherent in chiropractic adjustments:
As with any healthcare procedure, there are certain complications which may arise during chiropractic therapy and manipulation. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and seperations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatments. I will make every reasonable effort during the examintaion to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occuring:
Fractures are rare occurances and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and x ray (if applicable). Srtoke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options:
Other treatment options for your condition may include:
1. Self-administered, over the counter analgesics and rest. 2. Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers. 3. Hospitalization. 4. Surgery.

INFORMED CONSENT CONT.

If you decide to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to talk with your primary care doctor.

The risks and dangers attendant to remaining untreated:
Remaining untreated may allow for the formation of adhesions and reduce your mobility which may create a pain reaction further decreasing mobility. Over time this process can complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BOX AND SIGN BELOW:

I have read ☐ or have read to me ☐ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor of Chiropractic at Saunders Chiropractic Clinic PLLC of Allegan,MI and have had my questions answered to my satisfaction. 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 Saunders Chiropractic Clinic PLLC of Allegan, MI responsible for any erros or omissions that I may have made in the completion of this form. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____

_____
Patients Name (Please Print)

X_____
Signature of Patient, Parent or Legal Guardian (if a minor)

Dated:_____

_____
Doctors Name (Please Print)

X_____
Signature of Doctor