3097 29th St SE
Grand Rapids, MI 49512
Phone: 616-974-9922 Fax: 877-866-2053
www.health1stchiropractic.com

Patient Registration and History

Today's Date: ___________

Name: ____ Date of Birth: ___________

Address: _______________________________ City: ________________ State: ___ Zip: _______

Phone Number: _____________________/Alternate: __________________ Type: ________________

E-mail: ______________________________________ Social Security #: _________________________

Sex: M F Marital Status: Single Married Divorced Widowed

Occupation: ____________________________________ Employer: _________________________

Work Phone: ____________________________________

Insurance Company: ______________________________ *Please give card to staff for a copy.*

Name of *Primary Insured:* ___________________________________ Date of Birth: _______________

Relation to *Primary Insured:* _________________________________

In case of emergency, please contact: ____

Is there a possibility this condition may be involved in a lawsuit, litigation, attorney, or other third party (E.g. Worker's Comp, Auto Claim, Personal Injury, etc.)? Yes No

If yes, please name: ____

I authorize use of this form on all my insurance submissions. I authorize release of information to all my Insurance Companies. I understand that I am responsible for knowing my insurance coverage as I will be provided the most appropriate care deemed necessary without consideration or knowledge of my insurance plan. I understand a claim will be submitted to my insurance company as a courtesy. I understand that any services not covered are my responsibility. I understand I am responsible for my bill. I authorize Dr. Szagesh to act as my agent in helping me to obtain payment from my insurance company. I authorize payment directly to Health First Chiropractic Clinic, P.C. I permit a copy of this authorization to be used in place of the original.

I acknowledge that Dr. Szagesh of Health First Chiropractic Clinic, P.C. may be adjusting me and discussing my conditions and treatments in a joint adjusting area. If I have any questions, wish to be adjusted, or to discuss my health care in private, I have the option to schedule a time with the doctor in a private consultation or adjusting room.

I state that the above information is correct and adequate to the best of my knowledge.

____

Printed Patient Name

____ ____________________________

Printed Patient Representative Name (If applicable) Relationship to Patient

____ ____________________________

Patient (or Patient Representative Signature) Date

____ ____________________________

Health First Chiropractic Witness Date

Implemented 12/31/2014

Health History

Please Circle all the signs and symptoms you have or are concerned with on a regular basis. A complete history and understanding of your health status will help us to better facilitate care.

General Symptoms			
Wheezing	Fever	Night Sweats	Fainting
Dizziness	Nervousness	Convulsions	Fatigue
Loss of Weight	Numbness/Pain in arms/legs or hands/ feet	Headache of Migraine	Chills

Gastro-Intestinal			
Nausea	Poor Digestion	Hemorrhoids	Vomiting
Gall Bladder Trouble	Constipation/ Diarrhea	Pain over stomach	Belching or Gas
Colon Trouble	Liver Trouble	Excessive Hunger	Poor Appetite

Eye, Ear, Nose, and Throat			
Earache	Sinus Trouble	Poor Vision	Asthma
Sore Throat	Hoarseness	Nasal Obstruction	Nose Bleeds
Hoarseness	Enlarged Thyroid	Tonsillitis	Deafness

Genito-Urinary			
Frequent Urination	Painful Urination	Blood in Urine	Kidney Infection
Bed Wetting	Inability to Control Urine	Prostrate Trouble (Men Only)	

Muscles & Joints			
Weakness	Twitching (Spasms)	Stiff Neck	Back Pain
Swollen Joints	Tremors	Foot Trouble	Hernia

Cardiovascular			
Irregular Heartbeat	High or Low Blood Pressure	Pain over Heart	Varicose Veins
Poor Circulation	Swelling of ankles/ Edema	Heart Disease	History of Stroke

Skin		
Ace	Itching	Bruising Easily
Sensitive Skin	Hives	Eczema

Respiratory		
Chronic Cough	Spitting Blood	Spitting Phlegm
Chest Pain	Trouble Breathing	

Women Only			
Miscarriage	Painful Periods	Irregular Cycles	Hot Flashes
Cramps or Backaches	Pregnant (Due Date: _____)	Excessive Flow	Vaginal Discharge

Do you have/had any of the following?				
Diabetes	Chicken Pox	Multiple Sclerosis	Vaccinations	Gall Bladder
Anemia	Cancer (____________)	Mumps	Epilepsy	Thyroid
HIV/Aids	Lupus	Rheumatic Fever	Arthritis	Alcoholism
Polio/Measles	Tuberculosis	Sinus Surgery	Hernia	Stomach/Ulcer

Family History (Please list type)				
	Diabetes	Heart	Cancer	Arthritis
Mother				
Father				
Siblings				

Work Activity
Sitting (__ Hrs/Day)
Standing (__ Hrs/Day)
Light Labor
Heavy Labor

Habits
Smoking (__ Packs/Day)
Alcohol (__ Drinks/Wk)
Caffeine (__ Cups/Day)
High Stress

Exercise
None
Light (__ Hrs/Wk)
Moderate (__ Hrs/Wk)
Heavy (__ Hrs/Wk)

List any accidents or falls: ____

List any surgeries: ____

Have you had any broken bones or fractures? Yes No If yes, list: ______________________

Have you had spinal taps or injections? Yes No If yes, list: ______________________

Have you previously seen a Chiropractor? Yes No If yes, whom? ______________________

Thank you for your cooperation in filling out this form, to enable us to better care for your Health First.

How were you were referred to our office? ____

Patient Signature: ____ Date: _____________

Implemented 12/31/14

Health First Chiropractic Clinic, P.C.
"Caring for Your Health First"

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Medicare Consultation History

Mechanism of Injury (How did this injury happen):

Medicare requires an injury. Please circle one or more as applicable. If this is an ongoing pain, please mark what makes your pain worse. Speak to our staff if you have any questions.

Fell or Tripped	Exercising	Yardwork	Pushing
Reaching and pulling	Lifting (Please Name) ___________	Lifting/Wrestling/ Playing with Children/Others	Playing sports (Please Name) _____________
Bent forward	Twisted	Slipped on ice	Shoveling snow

Onset of Current Injury (When did this injury most recently occur):

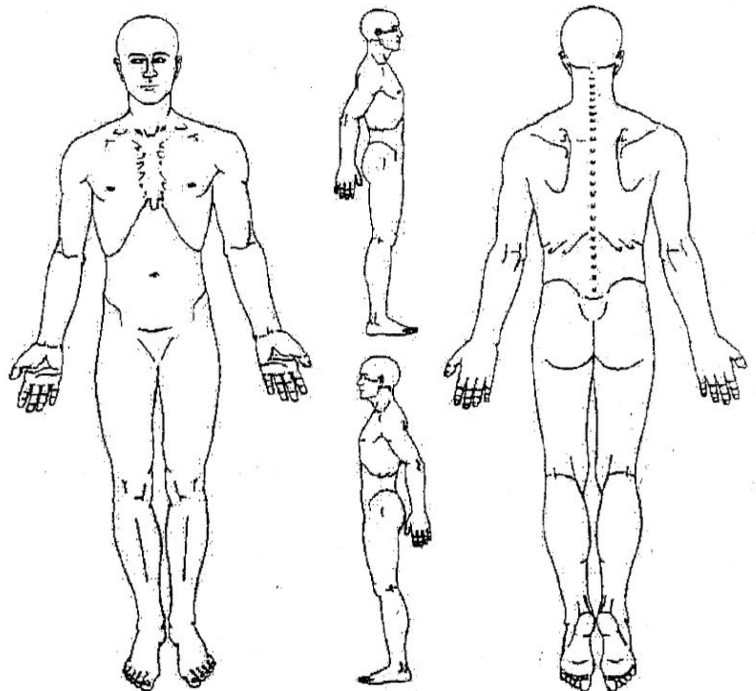
Less than 1	Hours
1, 2, 3, 4	Days
5, 6, 7, 8	Weeks
9, 10, 11, 12	Months

IF this injury has occurred before, *when* was the first occurrence? _______________________________

On the diagram, please indicate where you have any complaints (Primary and secondary).

Please use the following key to mark exact locations of your pain.

P = Sharp Pain (*Default*)
D = Dull Pain
T = Tingling
N = Numbness
B = Burning
S = Stiffness
A = Achy
R = Throbbing
K = Stabbing



Please circle the severity of your symptoms on a scale of 0—10.

None 0 1 2 3 4 5 6 7 8 9 10 Extreme

Implemented 12/17/14

Are your symptoms constant? Yes No

If *No,* please complete the following sentence regarding the *frequency and duration* of your pain. Not all portions need to be completed.

My pain occurs ________ time(s),

Less than 1x 1—3x 4—6x 7—9x More than 10x

...on a _____________ basis,

Daily Weekly Intermittent

...and lasts _____(1)_____ _______(2)_______,

(1) Less than 1 1—5 5—10 10—30 More than 30

(2) Minutes Hours Days Variable, Cannot Determine

Are there any *aggravating* factors? (What makes the pain worse?)

Nothing	Bending or Twisting	Exercising	Lifting more than 10 lbs
	Pulling	Reaching	Lifting more than 20 lbs
	Walking	Sitting	Lifting more than 50 lbs
	Laying down	Standing	Other: ______________

Are there any *relieving* factors? (What helps relieve the pain?)

Nothing	Heat or Ice	Prescription Drugs (Medical Marijuana, etc)	Non-Prescription Drugs (Tylenol, Advil, etc)
	Pillows	Rest	Laying down
	Sitting	Sleeping	Standing
	Stretching	Support Brace	Other: _________

Have you seen any other providers (MD, DO, DC, PT, Massage) for this injury? Yes No

If yes, please list: ____

Have there been any changes in your health history since this injury occurred? Yes No

If yes, please list: ____

Medical Affidavit: I do swear under oath, that the above information is true.

Patient Signature: ____ **Date:** ___________

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Pain Disability Questionnaire

Patient Name: ____ Date: ______________

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and circle the ONE number on EACH scale that best describes now you feel.

1. Does your pain interfere with your normal work inside and outside the home?
Work normally — Unable to work at all
0 1 2 3 4 5 6 7 8 9 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
Take care of myself completely — Need help with my personal care
0 1 2 3 4 5 6 7 8 9 10

3. Does your pain interfere with your traveling?
Travel anywhere I like — Only travel to see doctors
0 1 2 3 4 5 6 7 8 9 10

4. Does your pain affect your ability to sit or stand?
No problems — Cannot sit/stand at all
0 1 2 3 4 5 6 7 8 9 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
No problems — Cannot do at all
0 1 2 3 4 5 6 7 8 9 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
No problems — Cannot do at all
0 1 2 3 4 5 6 7 8 9 10

7. Does your pain affect your ability to run or walk?
No problems — Cannot walk or run at all
0 1 2 3 4 5 6 7 8 9 10

8. Has your income declined since your pain began?
No decline — Lost all income
0 1 2 3 4 5 6 7 8 9 10

9. Do you have to take pain medication every day to control your pain?
No medication needed — On pain medication throughout the day
0 1 2 3 4 5 6 7 8 9 10

10. Does your pain force you to see doctors more often than before your pain began?
Never see doctors — See doctors weekly
0 1 2 3 4 5 6 7 8 9 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
No problem — Never see them
0 1 2 3 4 5 6 7 8 9 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?
No interference — Total interference
0 1 2 3 4 5 6 7 8 9 10

13. Do you need the help of family and friends to complete everyday tasks because of your pain?
Never need help — Need help all the time
0 1 2 3 4 5 6 7 8 9 10

14. Do you now feel more depressed, tense, or anxious than before your pain began?
No depression/tension — Severe depression/tension
0 1 2 3 4 5 6 7 8 9 10

15. Are there emotional problems caused by your pain that interfere with your family, social, or work activities?
No problems — Severe problems
0 1 2 3 4 5 6 7 8 9 10

Patient Signature: ____ Date: ____________

Implemented 12/31/14

With Permission from: Anagnostis C et al: The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 1004: 29 (20): 2290-2302.