Confidential
Health Information

All information is confidential
Please allow staff to copy your Driver's license & insurance details
Please Print clearly.

Gilead Healing Center
306 S Creyts Rd
Lansing, MI 48917
517-319-5818
Fax 517-319-5872
www.gileadhealingcenter.com

____
Today's Date

Have you consulted a chiropractor before?
☐ No ☐ Yes When? ________ ________________________
If so, whom?

____
Whom may we thank for referring you?

________________________________ ☐ Male ☐ Female ______________________
Your LAST NAME **Date of Birth**

____________________________ _____________
Your FIRST NAME **Middle**

Marital Status
☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

____
Address

City **State** **Zip** **Home Phone** **Spouse's Name**

Email address **Cell Phone** **Child's Name & age**

Emergency Contact **Phone** **Child's Name & age**

Your Occupation

May we contact you at work?
☐ **yes** ☐ **no**

Your Employer

Insurance Carrier **Policy Number** **Family Doctor**

Who carries this policy: Self ☐ **Spouse** ☐ **Parent** ☐

Insured's Last Name (if not you)

Insured's First Name (if not you)

Insured's Employer

1. **The symptom (s) that have prompted me to seek care today include:** ***(Please list in order of GREATEST severity beginning with A.)***

A. ____

B. ____

C. ____

D. ____

E. ____

____
Patients Name

Doctor's Notes

2. And are they the result of (darken square):

☐ An accident or injury
☐ Work ☐ Auto ☐ Other ___________________
☐ A worsening long term problem
☐ An interest in: ☐ Wellness ☐ Other ________________

3. Onset (When did you first notice your current symptoms? Date: ___/___/___.

4. Intensity (How extreme are your current symptoms?)
0 ☐☐☐☐☐☐☐☐☐☐ 10
Absent -Uncomfortable- Agonizing

5. Timing (How often do you feel it?)
☐ Constant ☐ Comes & goes. How often?__________________________

6. Quality of symptoms
(What does it feel like?)
__Numbness
__Tingling
__Stiffness
__Dull
__Aching
__Cramps
__Nagging
__Sharp
__Burning
__Shooting
__Throbbing
__Stabbing
__Other______________

7. Location (Where does it hurt)
Circle area(s) on the illustration.

8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

____

9. **Aggravation or relieving factor** (Such as time of day, movements, certain activities, etc.
What tends to worsen the problem?___________________________
What tends to lessen the Problem? ___________________________

10. Prior interventions (What have you done to relieve the symptoms?)
___Surgery
___Ice
___Prescription Medication
___Acupuncture
___Heat
___Over the counter drugs
___Chiropractic
___Other_____
___Homeopathic remedies
___Massage
____
___Physical Therapy

11. What else should we know about your current condition? _________________________________

____

12. How does you current condition interfere with you:
-Work or career:____
-Recreational activities:____
-Household responsibility:____
-Personal relationship:____

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've *had* or currently *Have* <u>and initial to the right.</u>

____
Doctor's Initials

A. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
☐	☐	Osteoporosis	☐	☐	Arthritis	☐	☐	Scoliosis	☐	☐	Neck pain	☐	☐	back problem	☐	☐	Hip disorder	NONE___
☐	☐	Knee injuries	☐	☐	Foot/ankle pain	☐	☐	Shoulder problems	☐	☐	Elbow/wrist pain	☐	☐	TMJ issue	☐	☐	Poor posture	Initials_____

B. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
☐	☐	Anxiety	☐	☐	Depression	☐	☐	Headache	☐	☐	Dizziness	☐	☐	Pins & needles	☐	☐	Numbness	NONE___ Initials_____

C. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
☐	☐	High blood pressure	☐	☐	Low Blood pressure	☐	☐	High cholesterol	☐	☐	Poor circulation	☐	☐	Angina	☐	☐	Excessive bruising	NONE___ Initials_____

D. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
☐	☐	Asthma	☐	☐	Apnea	☐	☐	Emphysema	☐	☐	Hay Fever	☐	☐	Shortness of breath	☐	☐	Pneumonia	NONE___ Initials_____

E. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
☐	☐	Anorexia/Bulimia	☐	☐	Ulcer	☐	☐	Food sensitivities	☐	☐	Heartburn	☐	☐	Constipation	☐	☐	Diarrhea	NONE___ Initials_____

F. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
☐	☐	Blurred vision	☐	☐	Ringing in ears	☐	☐	Hearing loss	☐	☐	Chronic ear infection	☐	☐	Loss of smell	☐	☐	Loss of taste	NONE___ Initials_____

G. Integumentary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
☐	☐	Skin cancer	☐	☐	Psoriasis	☐	☐	Eczema	☐	☐	Acne	☐	☐	Hair loss	☐	☐	Rash	NONE___ Initials_____

(Continued from previous page) Patients Name______________________________

H. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
☐	☐	Thyroid issue	☐	☐	Immune disorder	☐	☐	Hypoglycemia	☐	☐	Frequent infection	☐	☐	Swollen glands	☐	☐	Low energy	NONE___ Initials_____

I. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
☐	☐	Kidney stones	☐	☐	Infertility	☐	☐	Bedwetting	☐	☐	Prostate issues	☐	☐	Erectile dysfunction	☐	☐	**PMS** symptoms	NONE___ Initials_____

J. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
☐	☐	Fainting	☐	☐	Low libido	☐	☐	Poor Appetite	☐	☐	Fatigue	☐	☐	Sudden weight change	☐	☐	Weakness	NONE___ Initials_____

PERSONAL

Past Personal, Family and Social History

Please identify your past health history: including accidents, injuries, illness & treatments. Please complete each section fully.

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

HAD HAVE

____ ____ AIDS
____ ____ Alcoholism
____ ____ Allergies
____ ____ Arteriosclerosis
____ ____ Cancer
____ ____ Chicken pox
____ ____ Diabetes
____ ____ Epilepsy
____ ____ Glaucoma
____ ____ Goiter
____ ____ Gout
____ ____ Heart disease
____ ____ Hepatitis
____ ____ Malaria
____ ____ Measles
____ ____ Multiple Sclerosis
____ ____ Mumps
____ ____ Polio
____ ____ Rheumatic fever
____ ____ Scarlet fever
____ ____ Sexually transmitted disease
____ ____ Stroke
____ ____ Tuberculosis
____ ____ Typhoid fever
____ ____ Ulcer
____ ____ Other:____________
____
____
____

15. Operations

Surgical interventions, which may or may not have included hospitalizations.

_____Appendix removal
____ Bypass surgery
____ Cancer
____ Cosmetic surgery
____ Elective surgery:_______
____
____ Eye surgery
____ Hysterectomy
____ Pacemaker
____ Spine _______________
____
____ Tonsillectomy
____ Vasectomy
____ Other: ______________
____
____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past Currently

____ ____ Acupuncture
____ ____ Antibiotics
____ ____ Birth control pills
____ ____ Blood transfusions
____ ____ Chemotherapy
____ ____ Chiropractic care
____ ____ Dialysis
____ ____ Herbs
____ ____ Hormone replacement
____ ____ Inhaler
____ ____ Massage therapy
____ ____ Physical therapy
____ ____ Nutritional supplements
List: ________________________
____
____
____ ____ Medications
(prescription & over the counter):
____
____
____
____
____

17. Injuries

Have you ever..

____ Had a fractured or broken bone
____ Had a spine or nerve disorder
____ Been knocked unconscious
____ Been injured in an accident
____ Used a crutch or other support
____ Used neck or back bracing
____ Received a tattoo
____ Had a body piercing

Doctor's Notes

FAMILY

18. Family History

Some health issues are hereditary. Tell us about the health of your

Relative	Age (if living)	State of health GOOD	POOR	Illnesses	age at death	Cause of death Natural	Illness
Mother	__________	____	_____	_________________________	___________	____	____
Father	__________	____	_____	_________________________	___________	____	____
Sister 1	__________	____	_____	_________________________	___________	____	____
Sister 2	__________	____	_____	_________________________	___________	____	____
Brother 1	__________	____	_____	_________________________	___________	____	____
Brother 2	__________	____	_____	_________________________	___________	____	____
________	__________	____	_____	_________________________	___________	____	____

19. Are there any other hereditary health issues that you know about? ______________________________

____

SOCIAL

20. Social History

Tell us about your heath habits and stress levels.

Alcohol use ___ Daily ___ Weekly How much? ________________
Coffee use ___ Daily ___ Weekly How much? ________________
Tobacco use ___ Daily ___ Weekly How much? ________________
Exercising ___ Daily ___ Weekly How much? ________________
Pain relievers ___ Daily ___ Weekly How much? ________________
Soft drinks ___ Daily ___ Weekly How much? ________________
Water intake ___ Daily ___ Weekly How much? ________________
Hobbies: ____

Prayer or meditation? ___ Yes ___ No
Job pressure/stress ? ___ Yes ___ No
Financial peace? ___ Yes ___ No
Vaccinated? ___ Yes ___ No
Mercury filling? ___ Yes ___ No
Recreational drugs? ___ Yes ___ No

Doctor's Initials

____

Name:________________________

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Sitting				
Rising out of chair				
Standing				
Walking				
Lying down				
Bending over				
Climbing stairs				
Using a computer				
Getting in/out of car				
Driving car				
Looking over shoulder				
Caring for family				

	No Affect	Mild Affect	Moderate Affect	Severe Affect
Grocery shopping				
Household chores				
Lifting objects				
Reaching overhead				
Showering or bathing				
Dressing myself				
Love life				
Getting to sleep				
Staying asleep				
Concentration				
Exercising				
Yard work				

22. What is the major stressor in your life? ___________________ 23. How much sleep do you average per night?_____Hr.

24. Is the type and approximate age of your pillow? ___________ 25. What is your preferred sleep position? ____________

26. Describe your typical eating habits: ___ Skip breakfast ___ Two meals a day ___ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? ______________________________
____

28. In addition to the main reason for your visit today, what additional health goals to you have? ______________________
____

Acknowledgements

To set clear expectations improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

____ Initials — I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

____ Initials — I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

____ Initials — 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 period (MM/DD/YYY) ______________________

____ Initials — I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in the office.

____ Initials — I acknowledge that any insurance I may have is an agreement between the carrier and me. I am responsible for all co-payments and deductible unless I have a hardship need.

____ Initials — To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor, print child's full name:____

____ ______________________________

Signature Date

Doctor's Notes

Doctor's Initials