Edison Chiropractic Wellness Center
105 S. Pearl St. Tecumseh, MI 49286

Patient Health Profile

Patient Information

Name: _____ **Preferred Name:** _____
Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
Date of Birth: _____ **Home Phone:** _____ **Cell Phone:** _____
Email Address: _____ **Gender:** _____ **Marital Status:** Married/Single/Other
Employer and Address: _____ **Work Phone:** _____
Referred By: _____ **Social Security Number:** _____
Financial Information: Insurance/Worker's Comp/Cash/Personal Injury (Auto)

Emergency Contact Information

Full Name: _____ **Phone Number:** _____
Relationship: Child/Parent/Spouse/Other: _____
Primary Care Physician: _____ **Phone Number:** _____

History of Current Condition

Describe Major Complaint: _____
Began When? _____ **Describe how this began:** _____
_____
Grade Intensity/Severity of Complaint: None/Mild/Moderate/Severe/Very Severe
Quality of the complaint/pain: Sharp/Stabbing/Burning/Achy/Dull/Stiff & Sore **Other:** _____
How frequent is the complaint present? Off & On/Constant
Does this complaint radiate/shoot to any areas of your body? No/Yes **Describe:** _____
Head – Base of skull/Forehead/Sides-Temple R/L/Both Leg – Hip/Thigh-Knee/Calf/Foot/Toes R/L/Both
Arm – Across shoulder/Elbow/Hands-Fingers R/L/Both **Other area:** _____
Does anything make the complaint better? Ice/Heat/Rest/Movement/Stretching/Medication **Other:** _____
Does anything make the complaint worse? Sit/Stand/Walk/Lying/Sleep/Overuse **Other:** _____
Which daily activities are being affected by this condition? _____
For this CURRENT condition, have you:
Received any other treatment? None/DC/MD/PT/Massage/ER Other: _____ Where: _____

- **Had any previous surgery previous interventions in this area?** _____
- **Taken any medications?** OTC/Prescriptions **List:** _____
- **Had any diagnostic testing?** X-Ray/MRI/CT **Other:** _____ **When and Where:** _____

Describe any Secondary Complaints: _____

Health History

Medications:
Allergies to Medications: NONE List: _____
_____
Current Medications: NONE
(Have a list? We can make a copy) _____
_____
_____

Past Health History: *(Please list any past)*
Surgeries-Date, type, and reason: NONE
_____
_____
Major Injuries/Traumas: NONE _____
_____
_____
Major Hospitalizations: NONE _____
_____

Family Health History:
List relevant major health problems of immediate relatives: _____
_____
_____
Deaths in immediate family: *(Cause and at what age)* _____
_____
_____

Social and Occupational History:
Level of education completed: _____
Lifestyle: *(Hobbies, Rec. Activities, etc.)* _____
_____
Habits:
Cigarettes-*(#/day)* _____
Alcohol-*(amount/day)* _____
Coffee/Tea *(cups/day)* _____
Recreational Drugs *(list)* _____

REVIEW OF SYSTEMS

Are you ***currently*** experiencing any of these symptoms? *(Check all that apply)*

Many of the following conditions respond to Chiropractic treatment.

General:
- ☐ Recent weight change
- ☐ Fever
- ☐ Fatigue
- ☐ None in this category

Musculoskeletal:
- ☐ Low back pain
- ☐ Mid back pain
- ☐ Neck pain
- ☐ Arm problems _____
- ☐ Leg Problems _____
- ☐ Painful joints
- ☐ Stiff/Swollen joints
- ☐ Sore/Weak muscles or joints
- ☐ Muscle spasms/Cramps
- ☐ Broken bones _____
- ☐ Other _____
- ☐ None in this category

Neurological:
- ☐ Numbness or tingling sensations
- ☐ Loss of feeling
- ☐ Dizziness or light headed
- ☐ Frequent or recurrent headaches
- ☐ Convulsions or seizures
- ☐ Tremors
- ☐ Stroke
- ☐ Have you ever had a head injury?
- ☐ Ever been in an auto accident?
- ☐ Other _____
- ☐ None in this category

Mind/Stress:
- ☐ Nervousness
- ☐ Depression
- ☐ Sleep problems
- ☐ Memory loss or confusion
- ☐ Other _____
- ☐ None in this category

Genitourinary:
- ☐ Sexual difficulty
- ☐ Kidney stones
- ☐ Burning/Painful urination
- ☐ Change in force/strain with urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Incontinence or bed wetting
- ☐ Other _____
- ☐ None in this category

Gastrointestinal:
- ☐ Loss of appetite
- ☐ Blood in stool
- ☐ Change in bowel movements
- ☐ Painful bowel movements
- ☐ Nausea or vomiting
- ☐ Abdominal pain
- ☐ Frequent diarrhea
- ☐ Constipation
- ☐ Other _____
- ☐ None in this category

Cardiovascular and Heart:
- ☐ Chest pains
- ☐ Rapid or heartbeat changes
- ☐ Blood pressure problems
- ☐ Swelling of hands, feet or ankles
- ☐ Heart problems
- ☐ Other _____
- ☐ None in this category

Respiratory:
- ☐ Difficulty breathing
- ☐ Persistent cough
- ☐ Coughing blood
- ☐ Asthma or wheezing
- ☐ Lung problems
- ☐ Other _____
- ☐ None in this category

Eyes and Vision:
- ☐ Wear contacts/glasses
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Eye disease or injury
- ☐ Other _____
- ☐ None in this category

Ears, Nose and Throat:
- ☐ Bleeding gums/mouth sores
- ☐ Bad breath or bad taste
- ☐ Dental problems
- ☐ Swollen throat or voice change
- ☐ Swollen glands in neck
- ☐ Ringing in the ears
- ☐ Ear-Ache/Ringing/Drainage
- ☐ Sinus/Allergy problems
- ☐ Nose bleeds
- ☐ Hearing loss
- ☐ Other _____
- ☐ None in this category

Endocrine, Hematologic, and Lymphatic:
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive thirst or urination
- ☐ Cold extremities
- ☐ Heat or cold intolerance
- ☐ Change in hat or glove size
- ☐ Dry skin
- ☐ Glandular or hormone problems
- ☐ Swollen glands
- ☐ Anemia
- ☐ Easily bruise or bleed
- ☐ Phlebitis
- ☐ Transfusion
- ☐ Immune system disorder
- ☐ Other _____
- ☐ None on this category

Skin and Breasts:
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Non-healing sores
- ☐ Change in appearance of a mole
- ☐ Breast pain
- ☐ Breast lump
- ☐ Breast discharge
- ☐ Other _____
- ☐ None in this category

Women Only:

Are you pregnant?
- ☐ Yes - Due Date _____/_____/_____
- ☐ No - Last menstrual period _____/_____/_____
- ☐ Infertility
- ☐ Painful or irregular periods
- ☐ Vaginal discharge
- ☐ Other
- ☐ None in this category

Pregnancies with outcomes and date:

_____

_____

_____

_____

_____

_____

Which of these topics interest you? *(Please check all that apply)*

☐ Diabetes ☐ High blood pressure ☐ Cancer ☐ Children's health ☐ Cleansing ☐ Supplementation ☐ Heart Health ☐ Naturopathy
☐ Healthy eating ☐ Fitness ☐ Weight loss ☐ Massage therapy ☐ Other _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature: _____ *Date:* _____