



401 S. Mechanic St., Jackson, MI 49201 • 517-513-3250 • info@ppcjackson.com

APPLICATION FOR CARE AT PARTNERSHIP PARK CHIROPRACTIC

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____

Birth Date: ____ - ____ - ____ Age: ____ Male Female

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

Home Phone: _____ Cell: _____ Email: _____

Is it ok to leave messages on your answering machine? Yes No

With whom may we leave a message with? _____

Relationship to patient: _____

Choose One: Minor Single Married Widow

Do you have Medicare? Yes No

Do you make your own financial decisions? Yes No

Employer: _____ Occupation: _____

Spouse/Guardian: _____

In case of emergency contact: _____ Relationship to patient: _____

Emergency Contact's phone number: _____

Whom may we thank for your referral? _____

HISTORY OF COMPLAINT

List your major complaints in order of severity and please indicate how long you have had each complaint.

1. _____

2. _____

3. _____

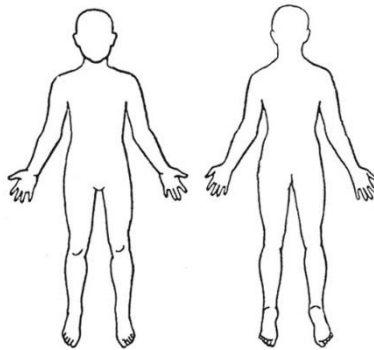
In regards to your primary complaint:

When did the problem begin? _____

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How did the problem begin? _____

Where is the problem? Please indicate on the chart below:



Is there anything that makes the problem **better**? _____

Is there anything that makes the problem **worse**? _____

How would you describe your pain? Burning Dull Achy Sharp Numb Tingly Tight

Does your pain travel? Yes No If yes, where? _____

On a scale of **0** to **10** with **0** being no pain and **10** being the worst pain, rate your pain by circling the number:

1 2 3 4 5 6 7 8 9 10

When is the problem at its worst? AM Mid-day PM Late PM

Has this problem ever happened before? No Yes; **If yes please explain:** _____

Has this condition been treated by anyone recently or in the past? No Yes; **If yes,**

When? _____ By whom? _____ How long were you under care? _____

What were the results? _____

What medications are you currently taking? _____

Is there anything else about your problem that is important to know? _____

PAST HEALTH HISTORY (for the following please include: date, type of care received if any and by whom)

Previous chiropractic care: _____

Do you wear a heel lift? No Yes; **if yes :** Right Left Both

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Auto accidents: _____

Concussions: _____

Additional accidents or injuries in the past year: _____

Any other significant injuries that occurred over 1 year ago: _____

Surgeries or fractures: _____

List all childhood diseases that you have had: _____

List all adult diseases that you have had: _____

Please mark any and all of the problems you currently have or ever have had:

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pregnant (now) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Frequent colds/flu | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Impotence/ Sexual dysfxn | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Jaw pain/ TMJ | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Heart problem |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> Double vision | <input type="checkbox"/> Colon trouble | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Pain w/ cough or sneeze | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Menopausal problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Depression | <input type="checkbox"/> PMS | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Foot or knee problems | <input type="checkbox"/> Swollen/Painful joints | <input type="checkbox"/> Irritable | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Skin problems | <input type="checkbox"/> Mood changes | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Gall bladder trouble |
| <input type="checkbox"/> Numbness/Tingling in arms, hands, fingers | | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Liver trouble |
| <input type="checkbox"/> Numbness/Tingling in legs, feet, toes | | <input type="checkbox"/> Allergies | <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Hepatitis (A, B, C) |

SOCIAL HISTORY

Smoking: daily weekends occasionally never

Alcoholic beverages: daily weekends occasionally never

Recreational drug use: daily weekends occasionally never

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Hobbies, recreational activities, exercise routine (please list):

Please describe your diet: _____

Please describe your sleeping habits and sleep quality: _____

FAMILY HISTORY

Does anyone in your family suffer from the same condition(s)? No Yes

If yes, what? _____

Whom? grandmother grandfather mother father sister brother son daughter

Any other hereditary conditions the doctor should be aware of? _____

TREATMENT GOALS

What are your expectations from receiving and maintaining your spinal correction at Partnership Park
Chiropractic? _____

Are you willing to be an active patient in the improvement of your health (ie. Dietary, exercise, and/or lifestyle
changes)? No Yes

As a result of my chiropractic care, I would like to (please check all that apply):

Feel better quickly Have a healthier body by keeping my nervous system healthy

Have a healthier spine Live a healthier lifestyle

What are your top 3 health goals?

1. _____

2. _____

3. _____

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I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I acknowledge that I am financially responsible to Partnership Park Chiropractic for any and all services I receive at this office and that payment is due at the time of service.

Patient Name (print)

Patient or Authorized Person's Signature

Date