



MICHIGAN CHIROPRACTIC SPECIALISTS

of Waterford, P.C.

Dr. Adam Apfelblat • 5140 Highland Road • Waterford • 48327

Welcome To Our Office

Thank you for choosing our practice for your chiropractic and massage needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PLEASE PRINT

PATIENT INFORMATION

Name: _____ Today's Date: _____

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

Social Security #: _____ - _____ - _____ Date of Birth: _____ Age: _____

Marital Status: _____ Sex: M F Number of Children: _____

Occupation: _____ Employer: _____

Spouse's Name: _____ Spouse's Employer: _____

E-mail Address: _____

How did you hear about our office (referred by)? _____

PHONE NUMBERS

Home Phone: (____) _____

IN CASE OF EMERGENCY CONTACT:

Work Phone: (____) _____

Name: _____

Cell Phone: (____) _____

Relationship: _____

Best Time And Place To Reach You Is:

Home Phone: (____) _____

Cell Phone: (____) _____

INSURANCE INFORMATION

Do You Have Health Care Insurance? Yes No Insurance Company: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's Relationship to Patient: _____

Is patient covered by additional insurance? Yes No If Yes, Please complete the following:

Insurance Company: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Relationship to Patient: _____

ACCIDENT INFORMATION

Are you here due to an: auto accident on the job injury other accident: _____

If so, please complete the following: Date of accident: _____

To whom have you reported the accident? Auto Insurance Workers Comp. Other

HEALTH HISTORY

Have you had previous chiropractic care? Yes No If Yes, Where: _____

When was your Last Adjustment? _____ Could you be Pregnant? Yes No

What are your Major/Primary Complaints?

How Long have they been Bothering you?

1) _____

1) _____

2) _____

2) _____

Have you ever had any falls, auto accidents, or injuries? Yes No If Yes, Please describe:

Month/Year _____ Type of Accident _____ Describe Injury _____

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Have you ever had surgery? Yes No If Yes, Please describe:

Month/Year _____ Type of Surgery _____ Comments _____

Month/Year _____ Type of Surgery _____ Comments _____

Are you currently taking medication or vitamins? Yes No If Yes, Please list:

Name _____ Doses Per Day _____ For how long _____

Name _____ Doses Per Day _____ For how long _____

Please check any of the following that you have experienced within the last 6 months:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Shooting head pain | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Pain in legs & feet | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Cold feet & toes | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Grinding in neck | <input type="checkbox"/> Painful joints | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Tightness in shoulders & arms | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Twitching of face | <input type="checkbox"/> Pain in shoulders & arms | <input type="checkbox"/> Constipation | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Pins & needles in arms & hands | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Stomach trouble |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness in arms or hands | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Cold hands or fingers | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Gall bladder trouble |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Intestinal gas |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> HIV + | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Numbness in legs or feet | <input type="checkbox"/> AIDS | Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No |

AUTHORIZATION

Assignment/Release of Information: I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this office or professional, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this office. I authorize this office to release any information pertinent to my case to any insurance company, adjustor, and/or attorney involved in this case.

Signature: _____ Date: _____

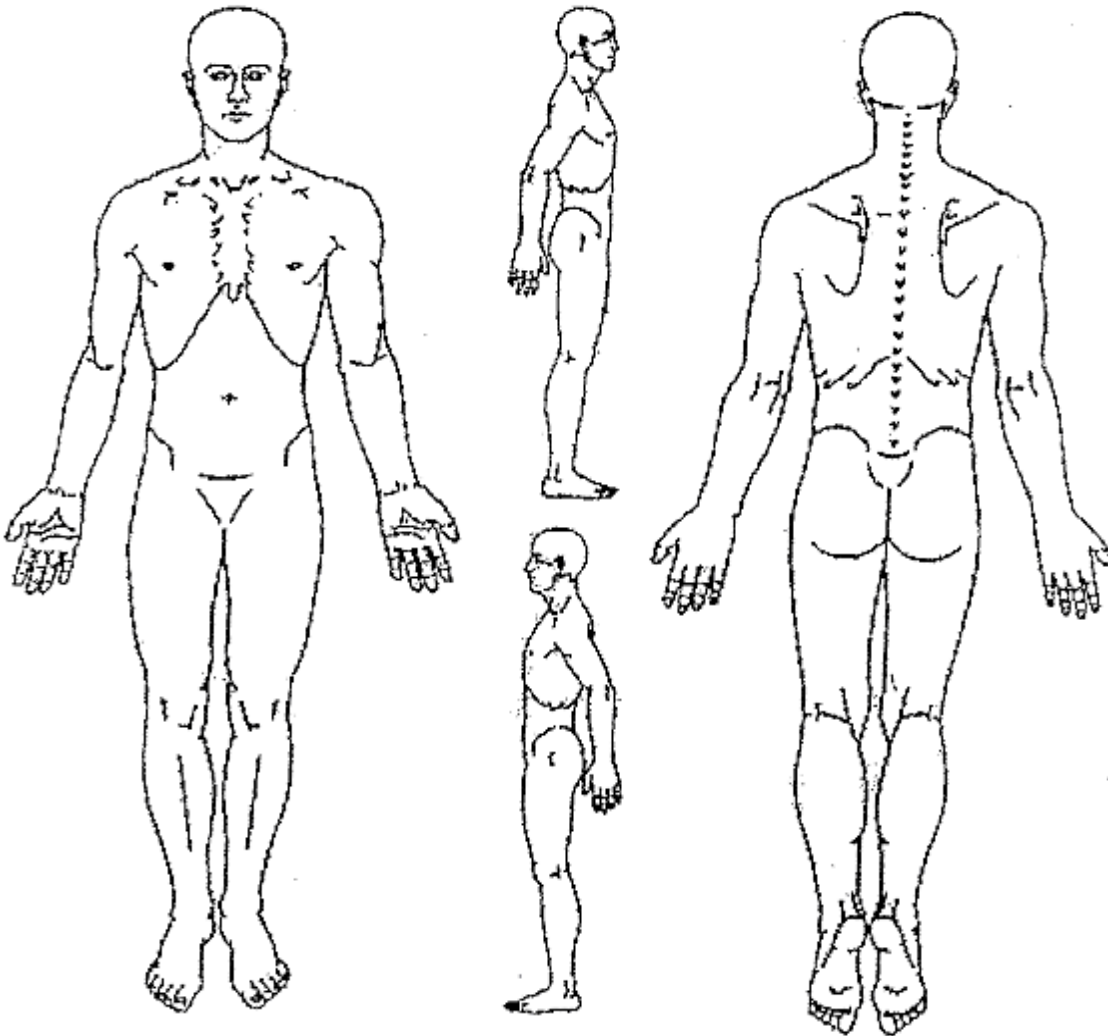
Financial Responsibility: I agree to be financially responsible for all charges incurred at this office including my insurance deductible, co-payment and any services rejected by my insurance company.

Signature: _____ Date: _____

PAIN DISABILITY INDEX QUESTIONNAIRE

Name: _____ Date: _____

On the diagram below, please indicate where you are experiencing any pain at this time. Use the code at the bottom to describe your pain. Please complete both sides of this form.



A = ACHE
P = PINS & NEEDLES

B = BURNING
S = STABBING

N = NUMBNESS
O = OTHER

(OVER PLEASE)

This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage everyday activities. Please answer each section by circling **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but just circle the one which closely describes your problem **right now**.

SECTION 1 – PAIN INTENSITY

- A. I have no pain at the moment
- B. The pain is mild at the moment
- C. The pain comes and goes and is moderate
- D. The pain is moderate and does not vary much
- E. The pain is severe but comes and goes
- F. The pain is severe and does not vary much

SECTION 2 – PERSONAL CARE

- A. I can look after myself without causing extra pain
- B. I can look after myself normally but it causes extra pain
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help, but manage most of my personal care.
- E. I need help every day in most aspects of self-care.
- F. I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 - LIFTING

- A. I can lift heavy weight without extra pain
- B. I can lift heavy weights, but it causes extra pain
- C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table
- D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- E. I can lift very light weights
- F. I cannot lift or carry anything at all

SECTION 4 – READING

- A. I can read as much as I want to with no pain in my neck
- B. I can read as much as I want with slight pain in my neck
- C. I can read as much as I want with moderate pain in my neck
- D. I cannot read as much as I want because of moderate pain in my neck
- E. I cannot read as much as I want because of severe pain in my neck
- F. I cannot read at all

SECTION 5 – HEADACHE

- A. I have no headaches at all
- B. I have slight headaches which come infrequently
- C. I have slight headaches which come frequently
- D. I have moderate headaches which come frequently
- E. I have severe headaches which come frequently
- F. I have headaches almost all the time

SECTION 6 – CONCENTRATION

- A. I can concentrate fully when I want to with no difficulty
- B. I can concentrate fully when I want to with slight difficulty
- C. I have a fair degree of difficulty concentrating when I want to
- D. I have a lot of difficulty concentrating when I want to
- E. I have a great deal of difficulty concentrating when I want to
- F. I cannot concentrate at all

SECTION 7 – WORK

- A. I get no pain at work
- B. I can do my usual work, but no more
- C. I can do most of my usual work with little pain
- D. I can do my usual work with moderate pain
- E. I can hardly do my usual work at all
- F. I cannot do any work at all

SECTION 8 – DRIVING

- A. I can drive my car without neck or back pain
- B. I can drive my car as long as I want with slight pain
- C. I can drive my car as long as I want with moderate pain
- D. I cannot drive my car as long as I want because of moderate pain
- E. I can hardly drive my car at all because of severe pain
- F. I cannot drive my car at all

SECTION 9 – SLEEPING

- A. I have no trouble sleeping
- B. My sleep is slightly disturbed (less than 1 hour sleepless)
- C. My sleep is mildly disturbed (1-2 hours sleepless)
- D. My sleep is moderately disturbed (2-3 hours sleepless)
- E. My sleep is greatly disturbed (3-5 hours sleepless)
- F. My sleep is completely disturbed (5-7 hours sleepless)

SECTION 10 – RECREATION

- A. I am able to engage in all recreational activities with no pain at all
- B. I am able to engage in all recreational activities with some pain
- C. I am able to engage in most, but not all recreational activities because of pain
- D. I am able to engage in a few of my usual recreational activities because of pain
- E. I can hardly participate in any recreational activities because of pain
- F. I cannot participate in any recreational activities at all

Signature: _____

Date: _____