ARBOR WEST CHIROPRACTIC CENTER

Mark J. Tobias, D.C., DIRECTOR

PLEASE COMPLETE ALL QUESTIONS ON BOTH SIDES OF THIS FORM

NAME (LAST NAME FIRST) _____ BIRTH DATE _____ SOCIAL SECURITY NO. _____

COMPLETE ADDRESS (INCLUDE CITY AND ZIP CODE) _____ HOME PHONE NUMBER _____

OCCUPATION _____ EMPLOYER _____ WORK PHONE NUMBER _____

☐ SINGLE
☐ MARRIED

NO. OF CHILDREN _____ SPOUSE'S NAME _____ SPOUSE'S HEALTH _____

HOW DID YOU HEAR ABOUT US? _____

Have you ever had chiropractic care?
☐ No
☐ Yes WHERE? _____

Is it possible you are pregnant?
☐ Yes ☐ No

☐ I have Medicaid
☐ I have Medicare

HEALTH INSURANCE _____ AUTO INSURANCE _____

EMAIL _____

PLEASE READ CAREFULLY AND SIGN

I AUTHORIZE DR. TOBIAS OR HIS STAFF TO RELEASE, AS HE DEEMS NECESSARY, ANY INFORMATION ACQUIRED IN THE COURSE OF MY CARE AT THIS CENTER.

I AUTHORIZE MY ATTORNEY AND/OR MY INSURANCE COMPANY TO SEND DIRECTLY TO DR. TOBAIS PAYMENT FOR CHIROPRACTIC CARE WHICH WOULD OTHERWISE BE PAID TO ME AND TO WITHHOLD FROM ANY SETTLEMENT, JUDGMENT OR VIRDICT THE AMOUNT NECESSARY TO PAY MY BILLS IN THIS OFFICE.

I AGREE TO PAY DR. TOBAIS THE DIFFERENCE, IF ANY BETWEEN THE COST OF MY CARE AND THE AMOUNT PAID TO HIM BY MY INSURANCE COMPANY AND/OR ATTORNEY.

X _____ X _____

PATIENT'S OR GUARDIAN'S SIGNATURE DATE

Present reason for Consulting the office

- ☐ I have no special problem: I understand the role of chiropractic in my general health care.
- ☐ I have **DISEASE/ SYMPTOM** (circle one) and I am interested in help with this specific problem; In addition I am interested in learning about my Health Potential and the role of chiropractic in Improving my family's health.
- ☐ I have a **DISEASE/SYMPTOM** (circle one) and I Am interested in help with this problem and in Learning how to PREVENT it in the future.
- ☐ I have a DISEASE/**SYMPTOM** (circle one) and I am **ONLY** interested in help with this specific problem.

Briefly Describe You're Chief Health Complaints & Symptoms

When and How Did This Problem Start

Describe Any Falls Injuries or Accidents

MONTH & YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY

List All Surgery Or Hospital Stays

MONTH & YEAR	REASON FOR SURGERY OR HOSPOTALIZATION

List All Drugs or Medications You Are Taking

NAME OF DRUG	AMOUNT TAKEN	NAME OF DRUG	AMOUNT TAKEN

Are your injuries the result of a ☐ auto accident ☐ WORK PLACE ACCIDENT? _____

DATE OF THIS ACCIDENT _____ DID YOU RETAIN A LAWYER? _____

ARE YOU DISABLED FROM WORK OR HOUSEHOLD TASKS? _____

HAVE YOU HAD THIS CONDITION BEFORE? _____

HAVE YOU OR ANYONE IN YOUR FAMILY EVER HAD ANY OF THE FOLLOWING CONDITIONS?

☐ CANCER ☐ DIABETES ☐ HEART CONDITON ☐ STROKE

PLEASE CHECK ANY OF THE FOLLOWING THAT AFFECT YOU

- ☐ Headache
- ☐ Fainting
- ☐ Heart attacks
- ☐ Constipation
- ☐ Shooting Pain
- ☐ Loss of balance
- ☐ High blood pressure
- ☐ Kidney trouble
- ☐ Sinus trouble
- ☐ Ringing in ears
- ☐ Low blood pressure
- ☐ Menstrual cramps & pain
- ☐ Loss of smell
- ☐ Wear glasses
- ☐ Anemia
- ☐ menstrual irregularity
- ☐ Hay fever
- ☐ Lights bother eye's
- ☐ Rheumatic fever
- ☐ Diabetes
- ☐ Asthma
- ☐ Muscle spasms in neck
- ☐ Nervous stomach
- ☐ Cancer
- ☐ Loss of taste
- ☐ grating in neck
- ☐ Stomach trouble
- ☐ sleeping problems
- ☐ Tightness of throat
- ☐ Tightness of shoulder Muscles
- ☐ Ulcers
- ☐ Painful joints
- ☐ Inflammation of throat
- ☐ Neuritis in shoulders & arms
- ☐ Nerves & nervousness
- ☐ Swollen joints
- ☐ Thyroid trouble
- ☐ Pins & needles in arms & hands
- ☐ Inner tension
- ☐ Arthritis
- ☐ Face flushed
- ☐ Cold hands
- ☐ Irritability
- ☐ Slipped disc
- ☐ twitching of face
- ☐ Chest pains
- ☐ Cold sweats
- ☐ Pinched nerves in back
- ☐ Loss of memory
- ☐ Shortness or breath
- ☐ Liver trouble
- ☐ Pins & needles in legs
- ☐ Fatigue
- ☐ T.B
- ☐ Gall bladder trouble
- ☐ Swollen ankles
- ☐ Depression
- ☐ Heart pain
- ☐ Indigestion
- ☐ Cold feet
- ☐ Head feels too heavy
- ☐ Heart palpitation

Intestinal gas

- ☐ Pains in legs and feet
- ☐ Dizziness
- ☐ Mid-back pain
- ☐ Low back pain
- ☐ Neck pain