Full Name: _____ **Date:** _____

Address: _____ **Mailing Address:** _____

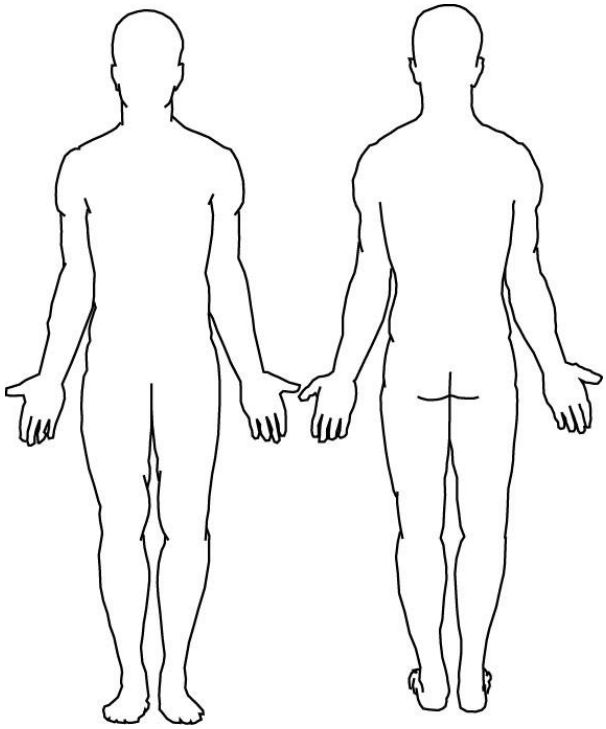
City/State/Zip: _____

Date of Birth: ____/____/_____ **Home Phone:** _____ **Cell:** _____

Email Address: _____

Spouse/Partner: _____ **Children (Names/Ages):** _____

Consent to Care Signature: _____



Please indicate where you pain is on the diagram shown to the left…

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Confidential Practice Member Information

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately and completely.

PLEASE CONTINUE TO THE NEXT PAGE…

The Power that Made the Body, Heals the Body

Dr. Erin Clifton

Dr. Sarah Prater-Manor

Positively Chiropractic: 134 E. Main, PO Box 360 – Stockbridge, MI – 49285 517-851-3850

Who can we thank for referring you here today? _____

Have you ever been to a chiropractor before? Y / N **Health Concerns:**

Health Concerns: In order of importance	Severity 1= Mild 10= Unbearable	How Long have you had this?	Did this start with an Injury?	Have you had this before?	Is this constant or comes and goes?
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____
4._____	_____	_____	_____	_____	_____
5._____	_____	_____	_____	_____	_____

On a scale from 1-10, with 10 being the highest, rate your commitment in helping us solve this problem: ____

How do your health concerns affect your daily life (brushing teeth or hair, getting dressed, doing dishes, etc.)?

_____

Main Complaint History:

1. How would you describe the pain?

☐ Sharp ☐ Soreness ☐ Throbbing ☐ Tingling ☐ Dull ☐ Stiffness
☐ Spasm ☐ Burning ☐ Ache ☐ Weakness ☐ Numbness ☐ Shooting

2. Does the pain travel anywhere else? ☐ Yes ☐ No Describe: _____

3. How often is this present?

☐ Constant (81-100%) ☐ Frequent (51-80%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

4. Since it started, has the pain gotten better, worse or stayed the same? _____
5. What makes your complaint worse?

☐ Nothing ☐ Walking ☐ Standing ☐ Sitting ☐ Exercise (Moving) ☐ Lying down ☐ Other

If "other" please explain: _____

6. Have you seen anyone else for this health concern? (I.e. Medical Doctor, Chiropractor, etc.) If so, who?

_____

PLEASE CONTINUE TO THE NEXT PAGE…

7. Please list all medications you are taking and what they are for:

_____

_____

_____

8. Please list any broken bones, surgeries, or hospitalizations you have had and when:

_____

_____

9. Please list any auto accidents you have been involved in:

_____

_____

10. How many glasses of PURE water are you drinking per day? _____

11. Do you participate in positive lifestyle habits?

☐ Exercise 4-5x/wk ☐ 4-5 servings of veggies/day ☐ 7-8 hours of restful sleep/night

IF THIS HEALTH INTAKE FORM IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD/MINOR

Name of patient who is a minor/child _____

I AUTHORIZE DR. ERIN CLIFTON, DR. SARAH PRATER-MANOR AND ANY AND ALL POSITIVELY CHIROPRACTIC STAFF TO PERFORM DIAGNOSITIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY POSITIVELY CHIROPRACTIC.

Guardian Signature: _____Date: _____

Guardian Relationship to minor/child: _____

Witness Signature (office staff): _____

PLEASE CONTINUE ONTO THE FAMILY HEALTH HISTORY ON THE NEXT PAGE….

Please CHECK OFF any of the conditions below that you (or your family) have or have had in the past: **Write "C" if current issue, or "P" if past issue…**

	Yourself	Spouse	Children	Mother	Father
Acid Reflux/Heartburn					
Allergies/Sinus Problems					
Arthritis					
Asthma					
Cardiac Conditions					
Disc Problems					
Dizziness					
Ear Infections					
Epilepsy					
Fainting					
Fatigue					
Headaches					
Irritable Bowel					
Kidney Condition/stones					
Liver Disease					
Lupus					
Menstrual Irregularity					
Migraines					
Nausea					
Nervousness					
Numbness					
Sciatica					
Scoliosis					
Sinus					
Stiffness					
Stomach Condition					
Thyroid Condition					
TMJ					
Ulcers					
Vertigo					