McLeod Chiropractic Center

Date: _____

# Welcome To Our Office!

1107 W. Broadway, Three Rivers, MI 49093
269-273-6712

First Name: _____ Last Name: _____ M.I.: _____

Address: _____
Residence City State Zip Code

Address: _____
Mailing City State Zip Code

Cell Phone: ( )_____Home Phone: ( )_____

Email: _____

Marital Status: __M __S __W __D Name of Spouse or Guardian: _____

Age: _____ Birthdate: ___/___/_____ Sex: __M __F Pregnant: __Y __N No. of Children: _____

Race: __African American __American Indian __Asian __Native Hawaiian __White

Ethnicity: __Hispanic/Latino __Not Hispanic/Latino Preferred Language: __English __Spanish

Smoker: __Yes, Everyday __Yes, Some days __Former Smoker __Never Smoked

Occupation: _____ Employer's Name: _____

WHO MAY WE THANK FOR REFERRING YOU TO US? _____

| List your problems or complaints according to severity: | Date started, or for how long? | If you had the condition before, when? | Did problem begin with an injury? |
|---|---|---|---|
| 1._____ | _____ | _____ | _____ |
| 2._____ | _____ | _____ | _____ |
| 3._____ | _____ | _____ | _____ |
| 4._____ | _____ | _____ | _____ |

Is your condition: ____Getting Worse ____Getting Better ____ Staying the Same

Is this condition interfering with your:

___Work ___Sleep ___Daily Routine ___Sports/Exercise ___Other: _____

What aggravates this condition? _____

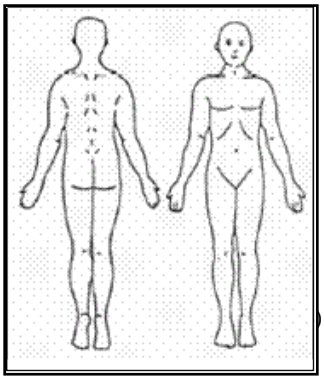
What relieves this condition? _____

What do you hope to do better, or enjoy more, as the result of our care? _____

_____

**On the diagram, use the codes below to illustrate your condition.**

**Code:** **N** = Numbness **P** = Pain **X** = Tenderness
**B** = Burning **T** = Tingling **M** = Muscle Spasm



Other doctor's seen for this condition? ___MD ___Chiropractor ___Dentist ___Other: _____

1. Name: _____Address: _____
   When? _____ What did they say was wrong? _____
2. Name: _____Address: _____
   When? _____ What did they say was wrong? _____

Name of previous chiropractor:_____ Date of last visit:_____
Are you taking any medications (drugs)? __No __Yes What? _____
Are you allergic to any medications? __No __Yes What? _____
Have any x-rays been taken? __No __Yes Area of body?_____

Accidents/Injuries: auto, work related or other (especially those related to your present problem).

1. Type: _____ When?:_____ Hospitalized?: __Y __N
2. Type: _____ When?:_____ Hospitalized?: __Y __N
3. Type: _____ When?:_____ Hospitalized?: __Y __N

**Note:** If you have **RECENTLY** been involved in an accident or injury, please inform a staff member so we can bring you our Accident/Injury report form. Thank you.

Please list all surgeries you have had:

1. Type:_____ When: _____ Doctor:_____
2. Type:_____ When: _____ Doctor:_____
3. Type:_____ When: _____ Doctor:_____
4. Type:_____ When: _____ Doctor:_____

Check the conditions you have had, or have now:

| | | | |
|---|---|---|---|
| __Allergy | __Diarrhea | __Measles | __Ringing in ears |
| __Eczema | __Miscarriage | __Stroke | __Epilepsy |
| __Anemia | __Emphysema | __Multiple sclerosis | __Heart attack |
| __Arteriosclerosis | __Gall bladder | __Mumps | __Tuberculosis |
| __Arthritis | __Gout | __Neuritis | __Thyroid |
| __Asthma | __High blood pressure | __Nervousness | __Ulcers |
| __Cancer | __Heart disease | __Depression | __Convulsions |
| __Constipation | __Menstrual cramps | __Pneumonia | __Low blood sugar |
| __Cold sores | __Irregular periods | __Neck pain | __Diabetes |
| __Migraines | __Headaches | __Back pain | __Sinus problems |
| __Psoriasis | __Other: | | |

Please describe anything we have not asked, but you feel we should know about: _____
_____

**Financial/Insurance Policy:**
I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. McLeod's office will prepare any necessary reports to assist me in making collection from my insurance company and that any amount authorized to be paid directly to the doctor will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patients Signature: _____ Date: _____

**Consent to Treat A Minor:** I hereby authorize this office to administer chiropractic care as deemed necessary for my child. Signature of Parent or Guardian: _____ Date: _____
Witness: _____