chiropractic

Bringing Out The Best In You!

Mitchell H. Marr, D.C.
Marr Chiropractic
70 S. Ortonville Road
Ortonville, MI 48462
(248) 627-8264
marrchiropractic.com

New Patient Welcome To Our Office

Date _____

Name _____ Preferred name _____

Address _____

City/State/Zip _____

Phone #s (home) _____ (cell) _____

Email address _____

SS # _____ Birthdate _____ Age _____

Occupation _____ Employer _____

Is it okay to contact you at work? ❍ no ❍ yes Work # _____

Marital status ❍ single ❍ married ❍ separated ❍ divorced ❍ widowed

Spouse's name _____ Phone #(s) _____

Children's names and ages _____

_____

Do you have any pets? ❍ no ❍ yes If yes, please tell us what kind(s) _____

_____

Favorite hobbies or interests _____

Emergency contact: Name _____

Relationship _____ Phone #(s) _____

What Brings You Here?

Have you ever had chiropractic care before? ❍ no ❍ yes

If yes, please tell us who _____ Phone # _____

Were you pleased with your care? ❍ no ❍ yes

How did you find out about our office? _____

Is this appointment related to ❍ work ❍ sports ❍ auto
❍ personal injury ❍ other _____

When did the incident occur? _____

Attorney (if applicable) _____ Phone # _____

Are you receiving care from other health professionals? ❍ no ❍ yes

If yes, please name them and their specialty _____

_____

Please list any drugs or medications you are taking _____

_____

Please list any vitamins/herbs/homeopathics/other you are taking _____

_____

_____

Are you pregnant? ❍ no ❍ yes If yes, what month? _____

This form continues. Please turn the page.

Current Health

What are your pressing health concerns? _____

_____

_____

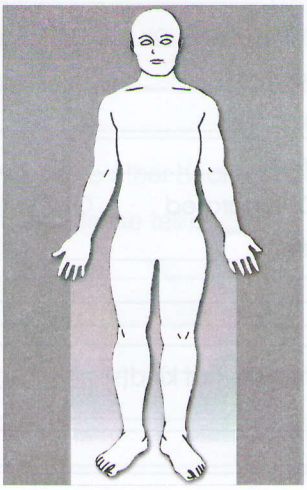
_____

_____

For how long? _____

Is it ❍ getting worse ❍ improving ❍ intermittent ❍ constant ❍ can't say

Where is the problem? Please use the illustrations and lines below to explain.



❍ Front _____

_____

_____

_____

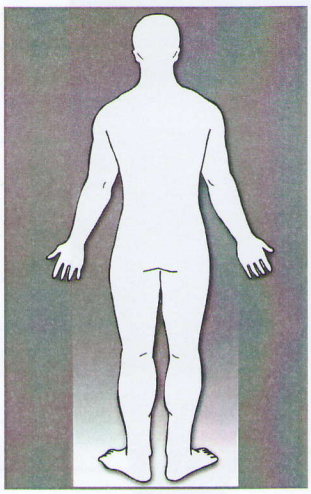
_____

❍ Back _____

_____

_____

_____



Do you have ❍ pain ❍ numbness ❍ tingling ❍ aches

Is your pain ❍ sharp ❍ dull ❍ throbbing ❍ constant ❍ intermittent

Are your symptoms affected by ❍ sitting ❍ standing ❍ walking

❍ bending ❍ lying down ❍ weather ❍ other

Please explain _____

_____

Do you feel ❍ cramps ❍ burning ❍ stiffness ❍ swelling ❍ other

Please explain _____

_____

_____

Do your symptoms interfere with ❍ work ❍ sleep ❍ day-to-day activities

❍ play ❍ other _____

Please explain _____

_____

_____

On a scale of 1-10 (1 least, 10 most), please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Health History

Do you have, or have you had, any of the following (please check ☑ all that apply)?

❍ pneumonia	❍ mumps	❍ influenza	❍ rheumatic fever	❍ smallpox
❍ pleurisy	❍ polio	❍ chickenpox	❍ thyroid disease	❍ diabetes
❍ epilepsy	❍ cancer	❍ depression	❍ whooping cough	❍ anemia
❍ eczema	❍ measles	❍ arthritis	❍ heart disease	❍ rashes
❍ colitis	❍ stroke	❍ allergies _____		

If you have ever been diagnosed with another disease or condition, please describe _____

_____

Do you drink ❍ coffee ❍ tea ❍ alcohol

Do you use ❍ cigarettes ❍ recreational drugs ❍ artificial sweeteners ❍ sugar

Have you ever suffered from (please check ☑ all that apply)

❍ neck pain	❍ difficulty breathing	❍ discolored urine
❍ low back pain	❍ stuffy nose	❍ gas/bloating after meals
❍ headache	❍ fainting	❍ heartburn
❍ migraines	❍ weight loss	❍ irritable bowel
❍ arm pain/tingling	❍ poor appetite	❍ black or bloody stools
❍ shoulder pain	❍ excessive appetite	❍ constipation
❍ hand pain/tingling	❍ nervousness	❍ hemorrhoids
❍ leg pain/tingling	❍ confusion	❍ liver problems
❍ jaw pain	❍ depression	❍ paralysis
❍ chest pain	❍ dental problems	❍ numbness
❍ lung problems	❍ excessive thirst	❍ fatigue
❍ heart problems	❍ frequent nausea	❍ dizziness
❍ abnormal blood pressure	❍ prostate problem	❍ loss of sleep
❍ irregular heartbeat	❍ breast pain/lump	❍ difficulty hearing
❍ ankle swelling	❍ cramps	❍ ear pain
❍ cold extremities	❍ painful urination	❍ other _____
❍ blurred vision	❍ bladder trouble	_____
❍ vision problems	❍ excessive urination	_____

If applicable, date of last menstrual period _____

Past injuries can affect present health (please check ☑ all that apply)

❍ falls/accidents	❍ head injuries	❍ fights	❍ surgery
❍ sports injuries	❍ broken bones	❍ dislocations	❍ other
❍ spinal tap	❍ knocked unconscious	❍ traction	_____
❍ use(d) a cane or walker	❍ extensive dental work	❍ dental applications	_____

If yes to any of the above, please describe _____

_____

_____

_____

_____

What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____

_____

Do you know what a subluxation is? ❍ no ❍ yes

If yes, please describe _____

_____

Do any friends or relatives see chiropractors: ❍ no ❍ yes

If yes, do they use chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

Are you seeking chiropractic for ❍ health maintenance/optimization

❍ health problems ❍ both

What would you like to gain from chiropractic care? _____

_____

_____

Are there other health concerns or anything else you'd like us to know about you? ❍ no ❍ yes

If yes, please tell us _____

_____

_____

_____

_____

_____

_____

_____

Financial Responsibility

Who is responsible for payment? _____

How will you pay for your care? ❍ Cash ❍ Check ❍ Credit Card

Credit card # _____ Exp. _____

Insurance co. _____ Phone # _____

ID # _____ Group # _____

Subscribers's name _____ Phone # _____

Relation _____ Subscriber's employer _____

Subscribers's SS # _____ Subscriber's birthdate _____

The above is accurate to the best of my knowledge.

_____ _____

(signature) (date)

I, parent/guardian, give permission for minor's care.

_____ _____

(signature) (date)