*6850 N. Rochester Rd. Rochester Hills, MI 48306*
*PHONE: (248)-923-1395 FAX: (248)-721-4083*

*Please allow our staff to make a copy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.*

Today's Date (MM/DD/YYYY)__________________ Whom may we thank for referring you? ____________________________________________

## PERSONAL

Last Name___________________________________________ First_________________________________ Middle(or Initial) _____________

Street Address ___________________________________________________________________________________________

City ________________________________________________________State/Province____________ ZIP/Postal Code__________________

Home Phone ______________________ Cell ________________________ Email Address __________________________________________

Gender ❍Male ❍Female Birth Date (MM/DD/YYYY) __________________ Social Security Number _______________________________

Marital Status ❍Single ❍Married ❍Divorced ❍Widowed ❍Separated Spouse's Name ________________________________________

Other Family Members ________________________________________________________________________________________

Occupation ______________________________________________________________________________________________

Employer __________________________________________________________________________Phone ____________________________

Preferred method of contact ❍Home Phone ❍Cell Phone ❍Work Phone ❍Email

Primary Care Physician ______________________________________________________________ Phone_____________________________

Emergency Contact ____________________________________________________ Phone Number _________________________________

## INSURANCE

Insurance Carrier_________________________________ Policy Number ________________________ Carried by ❍Self ❍Spouse ❍Parent

Insured's Last Name ______________________________________ First______________________________________ Middle Initial)_______

Insured's Birth Date (MM/DD/YYYY) __________________________________ Social Security Number _______________________________

Insured's Employer _______________________________________________________________ Phone _______________________________

Street Address ____________________________________________________________________________________________

City __________________________________________________________ State/Province___________ZIP/Postal Code__________________

## PREVIOUS CHIROPRACTIC CARE

Have you seen a Chiropractic Physician before? ___ Yes ___ No

Who? ______________________________________________________________________When? ___________________________________

Reason for Visit at that time: __________________________________________________________________________________

How did you respond? ________________________________________________________________________________________

## MEDICAL HISTORY

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

| Past | Present | Past | Present | Past | Present |
|---|---|---|---|---|---|
| □ | □ Headaches | □ | □ High Blood Pressure | □ | □ Diabetes |
| □ | □ Neck Pain | □ | □ Heart Attack | □ | □ Excessive Thirst |
| □ | □ Upper Back Pain | □ | □ Chest Pains | □ | □ Frequent Urination |
| □ | □ Mid Back Pain | □ | □ Stroke | □ | □ Smoking/Tobacco Use |
| □ | □ Low Back Pain | □ | □ Angina | □ | □ Drug/Alcohol Dependance |
| □ | □ Shoulder Pain | □ | □ Kidney Stones | □ | □ Allergies |
| □ | □ Elbow/Upper Arm Pain | □ | □ Kidney Disorders | □ | □ Depression |
| □ | □ Wrist Pain | □ | □ Bladder Infection | □ | □ Systemic Lupus |
| □ | □ Hand Pain | □ | □ Painful Urination | □ | □ Epilepsy |
| □ | □ Hip Pain | □ | □ Loss of Bladder Control | □ | □ Dermatitis/Eczema/Rash |
| □ | □ Upper Leg Pain | □ | □ Prostate Problems | □ | □ HIV/AIDS |
| □ | □ Knee Pain | □ | □ Abnormal Weight Gain/Loss | □ | □ Ankle/Foot Pain |
| □ | □ Loss of Appetite | □ | □ Jaw Pain | □ | □ Abdominal Pain |
| □ | □ Joint Pain/Stiffness | □ | □ Ulcer | □ | □ Arthritis |
| □ | □ Hepatitis | □ | □ Rheumatoid Arthritis | □ | □ Liver/Gall Bladder Disorder |
| □ | □ Cancer | □ | □ General Fatigue | □ | □ Tumor |
| □ | □ Muscular Incoordination | □ | □ Asthma | □ | □ Visual Disturbances |
| □ | □ Chronic Sinusitis | □ | □ Dizziness | □ | □ Other ______________________________ |

**For Females Only:** Birth Control Pills Hormonal Replacement Pregnancy

List all prescription medications you are currently taking ______________________________________________________________________

List all the over-the-counter medications you are currently taking ________________________________________________________________
List all Supplements and Herbs ____________________________________________________________________________________________

List all surgical procedures you have had ________________________________________________________________________________

## Social History:

| | | | | |
|---|---|---|---|---|
| Alcohol Use | ❍Daily ❍Weekly ❍Occasional | How much?_____________________________________ | Mercury Filling | Yes No |
| Coffee Use | ❍Daily ❍Weekly ❍Occasional | How much?_____________________________________ | Recreational Drugs | Yes No |
| Tobacco Use | ❍Daily ❍Weekly ❍Occasional | How much?_____________________________________ | | |
| Exercising | ❍Daily ❍Weekly ❍Occasional | How much?_____________________________________ | | |
| Pain Relievers | ❍Daily ❍Weekly ❍Occasional | How much?_____________________________________ | | |
| Water Intake | ❍Daily ❍Weekly ❍Occasional | How much?_____________________________________ | | |

Hobbies: ____________________________________________________________________________________

## Daily Living:

How much sleep are you getting per night? ______Hours Preferred Sleeping Position: ❍ Back ❍ Side ❍Stomach

Typical Eating Habits: ______________________________________________________________________________________________

In addition to the main reason for your visit, what are your other health goals? ___________________________________________________

## ACKNOWLEDGEMENTS

In order to set clear expectations, improve communication and help you attain the best results, please read each statement and **initial your agreement.**

_______ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered at Tranquility Chiropractic & Wellness is based on evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art form from medicine and does not proclaim to cure any named disease or entity.

_______ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_______ **FEMALES ONLY** I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY) ________________________

_______I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information, as an extension of my care in this office.

_______ I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for the payment of any covered or non-covered services that I receive.

_______ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

**If the patient is a minor child, print child's full name:** ________________________________________________________________

______________________________________________________ ________________________

**Signature** **Date**

## Insurance Policy and Fee Schedules

- Consultation includes practice member history. This is a complimentary service.
- Examination (new patient and established patient) includes one or more of the following: range of motion, motion and/or static palpation, muscle testing, dermatome testing, and leg check.
- Chiropractic Adjustment, this is the actual realignment of the vertebra, a manual or specific instrument spinal adjustment will be delivered to help re-align the vertebra.
- X-rays may be taken with specific views of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to help indicate progress after a period of care.

## Release of Authorization/Assignment of Benefits

I authorize the release of any information necessary to process my insurance claims. I authorize and request payment of insurance benefits directly to Dr. Jennifer Fabro, DC. I agree that this authorization will cover all services rendered until I revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for the service when rendered unless other arrangements have been made in advance. I understand that I am Financially responsible for any charges not covered by this assignment.

**Signature** **Date**