

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 PhoneC	Cell Email Address				
Gender OMale OFemale Birth Date (I	MM/DD/YYYY) Social Security N	umber			
Marital Status OSingle OMarried ODivo	rced OWidowed OSeparated Spouse's Name				
Other Family Members					
Employer		Phone			
Preferred method of contact OHome Pho	one OCell Phone OWork Phone OEmail				
Primary Care Physician		Phone			
Emergency Contact	Phone Num	ber			
INSURANCE					
Insurance Carrier	Policy Number	Carried by OSelf OSpouse OParent			
Insured's Last Name	First	Middle Initial)			
Insured's Birth Date (MM/DD/YYYY)	Social Security Nu	mber			
Insured's Employer	F	hone			
Street Address					
	State/Province	ZIP/Postal Code			
PREVIOUS CHIROPRACTIC CARE					
Have you seen a Chiropractic Physician be	fore? Yes No				
Who?	When	?			
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.							
	Present		Present		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		
	•		□ 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:							
Alcoh Coffee Tobac Exerci Pain F Wate	ol Use  Daily OWeekler  Daily OWeekler  Daily OWeekler  Daily OWeekler  Daily OWeekler  Daily OWeekler  Daily OWeekler	y 000 y 000 y 000 y 000 y 000	casional How much?		Recreational Drugs Yes No		
Daily Living:							
How much sleep are you getting per night?Hours Preferred Sleeping Position: O Back O Side OStomach							
Typical Eating Habits:							
In add	In addition to the main reason for your visit, what are your other health goals?						

## 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 Health Loft Chiropractic 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. Marie Palazzolo-Meyer, 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.

**Date** 

**ACKNOWLEDGEMENTS** 

Signature