Tranquility Chiropractic & Wellness

3230 S. Rochester Rd. Rochester Hills, MI 48307
PHONE: (248)-923-1395

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?_____
Coffee Use ❍Daily ❍Weekly ❍Occasional How much?_____
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: _____

Mercury Filling Yes No
Recreational Drugs Yes No

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 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.

Signature **Date**