Progressive Chiropractic
716 W. Eleven Mile Road
Royal Oak, MI, 48067
(248) 544-9009

Date: _____

Patient Number: _____

We would like to thank you for entrusting us with your health. Please take your time and fill out as much information as possible.

Name: _____ □ Male □ Female Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Cell Phone: _____ Home Phone: _____

□ Married □ Single #Children: ____ Occupation: _____ Employer: _____

Main activities performed at work: _____

Have you had Chiropractic care before: □ Yes □ No If yes, where? _____

Who may we thank for referring you to our office? _____

Do you have health insurance? □ Yes □ No If yes, what is the company name? _____

Are you covered by Medicare? □ Yes □ No Height _____ft _____in Weight _____ lbs

Have you ever had any broken bones, torn ligaments or major injuries? □ Yes □ No Please explain with dates:

_____

_____

Have you ever had surgery? □ Yes □ No Please explain with dates:

_____

_____

Are you presently taking any medication or vitamins? □ Yes □ No If yes, please list:

_____ for what condition(s)? _____

_____ for what condition(s)? _____

_____ for what condition(s)? _____

If you are currently taking more than 3 medications, please make a list of them for our records.

What are you hoping for from your visit to our office? _____

_____

What activities could you do before your symptoms started that you can't do now? _____

_____

Please continue to the back of this form.

	Primary Complaint	Secondary Complaint	Tertiary Complaint
Where are your complaints? (circle one per complaint)	☐ Headache ☐ Neck ☐ Mid Back ☐ Low Back ☐ Left Hip ☐ Right Hip ☐ Left Leg ☐ Right Leg ☐ Left Shoulder ☐ Right Shoulder ☐ Left Arm ☐ Right Arm	☐ Headache ☐ Neck ☐ Mid Back ☐ Low Back ☐ Left Hip ☐ Right Hip ☐ Left Leg ☐ Right Leg ☐ Left Shoulder ☐ Right Shoulder ☐ Left Arm ☐ Right Arm	☐ Headache ☐ Neck ☐ Mid Back ☐ Low Back ☐ Left Hip ☐ Right Hip ☐ Left Leg ☐ Right Leg ☐ Left Shoulder ☐ Right Shoulder ☐ Left Arm ☐ Right Arm
When did your symptoms begin?	_______Days ago _______ Months Ago	_______Days ago _______ Months Ago	_______Days ago _______ Months Ago
What caused this condition?			
What makes it worse?	☐ Lifting ☐ Prolonged Sitting ☐ Prolonged Standing ☐ Bending/Twisting ☐ Coughing ☐ Lying down ☐ Stress ☐ Walking ☐Standing Up (After Sitting)	☐ Lifting ☐ Prolonged Sitting ☐ Prolonged Standing ☐ Bending/Twisting ☐ Coughing ☐ Lying down ☐ Stress ☐ Walking ☐Standing Up (After Sitting)	☐ Lifting ☐ Prolonged Sitting ☐ Prolonged Standing ☐ Bending/Twisting ☐ Coughing ☐ Lying down ☐ Stress ☐ Walking ☐Standing Up (After Sitting)
What makes it better?	☐ Resting ☐ Sitting ☐ Standing ☐ Lying Down ☐ Ice ☐ Heat ☐ Adjustments ☐ Massage	☐ Resting ☐ Sitting ☐ Standing ☐ Lying Down ☐ Ice ☐ Heat ☐ Adjustments ☐ Massage	☐ Resting ☐ Sitting ☐ Standing ☐ Lying Down ☐ Ice ☐ Heat ☐ Adjustments ☐ Massage
Describe the pain (circle all that apply)	☐ Sharp ☐ Dull/Achy ☐ Burning ☐ Numbness ☐ Tingling ☐ Throbbing ☐ Pins/Needles ☐ Stiffness	☐ Sharp ☐ Dull/Achy ☐ Burning ☐ Numbness ☐ Tingling ☐ Throbbing ☐ Pins/Needles ☐ Stiffness	☐ Sharp ☐ Dull/Achy ☐ Burning ☐ Numbness ☐ Tingling ☐ Throbbing ☐ Pins/Needles ☐ Stiffness
Does the pain move (radiate) to other areas of your body?	☐ Left Hip ☐ Right Hip ☐ Left Leg ☐ Right Leg ☐ Left Shoulder ☐ Right Shoulder ☐ Left Arm ☐ Right Arm	☐ Left Hip ☐ Right Hip ☐ Left Leg ☐ Right Leg ☐ Left Shoulder ☐ Right Shoulder ☐ Left Arm ☐ Right Arm	☐ Left Hip ☐ Right Hip ☐ Left Leg ☐ Right Leg ☐ Left Shoulder ☐ Right Shoulder ☐ Left Arm ☐ Right Arm
From 0-10 (10 being the worst) how would you rate your pain today?	☐ 1/10 ☐ 2/10 ☐ 3/10 ☐ 4/10 ☐ 5/10 ☐ 6/10 ☐ 7/10 ☐ 8/10 ☐ 9/10 ☐ 10/10	☐ 1/10 ☐ 2/10 ☐ 3/10 ☐ 4/10 ☐ 5/10 ☐ 6/10 ☐ 7/10 ☐ 8/10 ☐ 9/10 ☐ 10/10	☐ 1/10 ☐ 2/10 ☐ 3/10 ☐ 4/10 ☐ 5/10 ☐ 6/10 ☐ 7/10 ☐ 8/10 ☐ 9/10 ☐ 10/10
How often does your pain bother you? (10-100% of the time)	☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%	☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%	☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Doctor Use Only

____

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____

Patient Signature: ______________________________ Date: ______________________