Madison Heights Chiropractic Center

28107 John R Madison Heights, MI 48071 **248-542-3492**

OFFICE PROCEDURE & PATIENT INFORMATION

Welcome to the Madison Heights Chiropractic Center. This clinic is a full service analytic and rehabilitative facility, offering some of the most advanced and sophisticated equipment available.

The Madison Heights Chiropractic center specializes in structural and nerve related conditions, spinal manipulations, disc regeneration techniques, nutrition, and rehabilitative care, with a holistic approach to body-health relationships. This clinic recognizes that spinal structural alignment, nerve interference, and disc conditions all play a significant role in the maintenance of the healthy body. We attempt to be as conservative as possible in our approach to health care, and want our patients to understand their particular problem. Therefore, we will sit down with you, after the exam, and explain what is wrong and what must be done to improve your condition.

This Clinic accepts patients for treatment in the following ways:

1. **Acute** - (Not complex or chronic in nature, with no involved examination findings) The patient is treated on a visit-by-visit basis, or unit of care.

2. **Chronic/Complex** - (Conditions which have not responded to other forms of treatment or shown by examination to be complex, long standing, and require greater attention) Patient is accepted on a stabilization basis. Treatment is determined on the severity of the condition and what needs to be done. Fees are proportional to the complexity of the problem and may be paid on a visit-by-visit basis or special arrangement. If examination reveals appropriate findings, then the possibility of a Neurosurgical consultant or other health practitioner must be considered.

3. Nutritional supplements, post manipulative soft tissue techniques, disc reduction for reduction for regeneration, realignment and expansion, adjust rehabilitative intermittent intersegmental traction, rehabilitative exercise programs, and spinal stabilization supports may also be recommended.

Please indicate your desires below and fill out the information on the attached form.

Type of Service Desired

_____ 1. Temporary Relief
_____ 2. General Stabilization
_____ 3. Specific Correction if Possible (Optimum Healthcare)

How Would You Classify Your Condition?

_____ 1. Minor
_____ 2. Involved
_____ 3. Fairly Severe & Progressively Getting Worse
_____ 4. Serious & would like to know the cause and correction.

(Blue Care Network- (BCN) requires a global referral covering initial visit & follow-up visits. This also has to be renewed each year on the anniversary of the last referral provided. Please ask the front desk if you are unsure if this applies to you.)**

(Blue Care Network Advantage (BCN Medicare) requires a plan notification (COT) referral from your primary care physician (PCP) prior to care. This must be completed for your insurance to consider your coverage.)**

PERSONAL INFORMATION

Date_____ Social Security No._____

Patient Name_____ Male____ Female____ Other____
(last) (first) (middle initial)

Address_____City_____State_____Zip_____

Email_____

(Email is required for Patient Portal Access)

Cell Phone_____ Home Phone_____ **Are you Pregnant? YES NO Unsure**

Date of Birth_____ Age_____
(month) (day) (year)

Single ____ Married ____ Separated ____ Divorced ____ Widowed ____ Number of Children _____

Name of Spouse_____ Name of Children_____

Patient's Occupation or Profession_____

Employed by_____ Business Phone_____

Is the above patient under the age of 18? ___ No ___ Yes If Yes, Parent/Guardian please complete line below:

Name_____ Relationship_____ SSN#_____

Address _____ Phone _____

Primary Care Physician (PCP) Name _____ Phone Number _____

Date of your last visit with your PCP & Yearly Physical:_____

Past Surgeries_____

_____

How did you hear about our office? **Referred by** _____

Have you had an X-Ray/MRI/CT (circle) done within the past year? YES / NO Where? Neck Mid-Back Low Back

Have you had chiropractic before?_____Where?_____

Have you had Pain Management: _____ Current _____ Previous _____ Never

Do you have health insurance? No Yes If yes:_____ Policy# _____

Do you have any of the following(circle): HSA FSA None

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? IF YES, MARK "X

(This applies to current symptoms as well as those that you have experienced in the past, from birth to present day)

( ) Acid Reflux/Heartburn
( ) Allergies
( ) Arthritis
( ) Asthma
( ) Base of Neck Pain
( ) *Balance/Coordination Problems*
( ) Bladder Troubles
( ) *Bleeding Disorders*
( ) *Blood in Urine or Stool*
( ) Breast Implants
( ) *Bruising Easily*
( ) Bulging Disc
( ) Bypass Surgery
( ) Cancer
( ) Chest Pain
( ) *Chronic Lung Disease*
( ) Clicking or Grinding in Neck
( ) Cluster Headaches
( ) Cold Feet
( ) Constipation
( ) Cool Hands
( ) Depression
( ) Diarrhea
( ) *Dizziness*
( ) Double Vision
( ) Drop Attack
( ) Ear Infections
( ) *Ehlers-Danlos (Type IV)*
( ) Fatigue
( ) Frequent Urination
( ) *Fibromuscular Dystrophy*
( ) Gall Bladder Trouble
( ) Head Feels Heavy
( ) Headaches
( ) Heart Attack
( ) Heart Problems
( ) Heart Trouble
( ) Herniated Disc
( ) Hip Pain
( ) *Hypertension/HBP*
( ) *Lightheadedness*
( ) Indigestion
( ) Inner Tension
( ) Intestinal Gas
( ) Irritability
( ) Jaw Pain
( ) Kidney Trouble
( ) Knots in the Back Muscle
( ) Light Bother Eyes
( ) Loss of Balance
( ) Low Back Pain
( ) Lower Mid Back Pain
( ) *Marfans*
( ) Menstrual Cramps and Pain
( ) Menstrual irregularity
( ) Mid Back Pain
( ) Mid Back Pain when Sleeping
( ) Migraines
( ) Muscle Spasms in Mid/Low Back
( ) Muscle Spasms in Neck
( ) Nausea or Upset Stomach
( ) Neck Pain
( ) *Numbness/Weakness of head or face*
( ) Numbness of Arm or Hand
( ) Numbness of Legs or Feet
( ) *Nystagmus/Rapid Eye Mov't*
( ) Pain in Shoulder Blades
( ) Pain into feet
( ) Pain into Legs
( ) Pain into the Buttock
( ) Painful Joints
( ) Pinched Nerve
( ) Pins and Needles in Arms/Hands
( ) Pins and Needles in Back/Legs/Feet
( ) *Polycystic Kidney Disease*
( ) Poor Circulation
( ) Postmenopausal
( ) Ringing in Ears
( ) Sciatic Pain
( ) Sexual Dysfunction
( ) Shooting Head Pain
( ) Shoulder Pain
( ) Shoulder Tightness
( ) Sinus Trouble
( ) Snoring
( ) Stiff Mid Back
( ) Stiff Neck
( ) Stomach Disorder
( ) *Strokes*
( ) Swollen Joints
( ) Throbbing Head Pain
( ) Thyroid Trouble
( ) Tingling in Fingers
( ) Trouble Bending
( ) Trouble Sleeping
( ) *Trouble Speaking (Speech)*
( ) *Trouble Swallowing*
( ) Trouble Twisting
( ) Ulcers
( ) Upper Back Pain
( ) *Upper Respiratory Infection*
( ) *Urinary Tract Infections*
( ) Vascular Disease
( ) *Vision problems*

_____(patient initial) - I deny experiencing any of the above symptoms/conditions.

Personal History: **(circle all conditions that apply)**

Anemia, Arthritis, Arteriosclerosis (hardening/thickening of artery walls), Asthma, Cancer: _____, Cardiovascular Problems (Circulation issues, Swelling, etc), Congestive Heart Failure, COPD, COVID, Crohn's, Depression, Diabetes, Dizziness/Fainting, Headaches, Heart Disease, Heart Attack, Heart Problems, Hepatitis, HIV, High Blood Pressure, Hypertension, Irritable Bowel Syndrome, Kidney Problems, Liver Disease, Low Blood Pressure, Osteoporosis, Pacemaker, Respiratory Problems, Rheumatoid Arthritis, Seizures, Stroke,Systemic Disease, Tuberculosis, Thyroid Problems, Other: _____

***Have you received the COVID19 Vaccine? ___ No ___ Yes. Have you had the COVID virus? ___ No ___ Yes**

(This question MUST be answered for our records)

Have you ever experienced in your lifetime any of the following: (circle all that apply)

Back Problems Sciatica Disc Disease Neck Problems Headaches None

In the past (at any time in your lifetime) have you had any: (circle all that apply)

Car Accidents Falls Work Injuries Sports Injuries None

Family History:

Has your mother had any of the above conditions? YES / NO, IF Yes, list conditions? _____

Is your mother deceased? YES / NO

Has your father had any of the above conditions? YES / NO, IF Yes, list conditions? _____

Is your father deceased? YES / NO

Have your grandparents, sister, brother had any of the above conditions? YES / NO, IF Yes, list conditions?_____

_____

Social History:

Do you drink alcohol? Yes / No If Yes, How Many? 1-2 3-4 5+ How Often? Daily Weekly Monthly Occasional/Social

Do you (circle one) smoke/vape tobacco? Never Former smoker Occasional/social (Light) Current (Daily) Smokeless tobacco

Do you (circle one) smoke / vape: Marijuana THC CBD Other:_____

Do you use (circle): THC / CBD products

Have you used illegal drugs? Yes / No

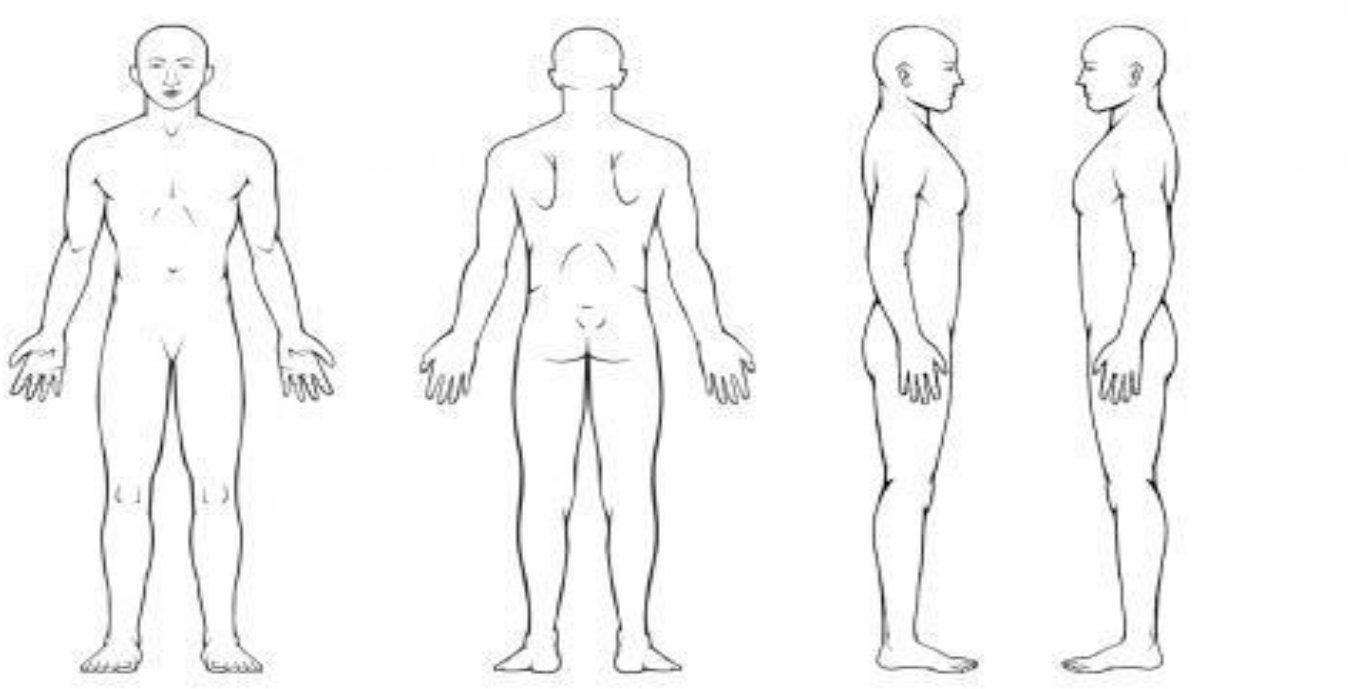
Do you exercise? YES / No, If Yes Circle one: Daily Weekly Monthly

If Yes, What Kind? Yoga/Pilates Weight Training Running/Jogging Other: _____

Primary Condition(s)?
When did the condition(s) start? unknown ____ or date:_____ Duration of Condition(s)?
Have you had the problem previously? YES NO, If Yes how long ago?
Have you been treated for other conditions or areas that are not currently the primary problem?
What previous treatment have you had?
What are you doing for it now?
What have you found to be effective?
Are you seeing another doctor for any reason, Including pregnancy? YES NO **If Yes, please explain:**
What medications and/or supplements are you currently taking? (if not already provided)

Use the letters below to indicate the type of pain and location(s):

A= **Ache**
B= **Burning**
N= **Numbness**
P= **Pins and Needles/Tingling**
S= **Stabbing**
0= **Other**



I certify that the given information is true and complete to the best of my knowledge:

Patient's Signature: _____
(Parent if patient is a minor)

_____

Official Use Only:

Additional Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Madison Heights Chiropractic Center

General Pain Index Questionnaire

Please mark how much your pain presently **prevents** you from doing what you would normally do. Regarding each category, please indicate the **overall** impact your present pain has on your life, not just when the pain is at its worst. Please **circle the number** which best describes how your typical level of pain affects these six categories of activities.

1. **Family at home responsibilities:** such as yard work, chores around the house or driving the kids to school

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

2. **Recreation:** including hobbies, sports or other leisure activities

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

3. **Social activities:** including parties, theater, concerts, dining out and attending other social functions

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

4. **Employment:** including volunteer work and homemaking tasks

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

5. **Self-care:** such as taking a shower, driving or getting dressed

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

6. **Life-support activities:** such as eating and sleeping

0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

Patient name(Print): _____

Patient Signature: _____ Date: _____

Patient Quality of Life Survey

Company Information: _____

Name: _____ **Date:** _____

Please take several minutes to answer these questions so we can help you get better.
(Please check all that apply)

01 How have you taken care of your health in the past?

- ☐ Medications
- ☐ Emergency Room
- ☐ Routine Medical
- ☐ Exercise
- ☐ Nutrition/Diet
- ☐ Holistic Care
- ☐ Vitamins
- ☐ Chiropractic
- ☐ Other (please specify): _____

02 How did the previous method(s) work out for you?

- ☐ Bad Results
- ☐ Some Results
- ☐ Great Results
- ☐ Nothing Changed
- ☐ Did Not Get Worse
- ☐ Did Not Work Very Long
- ☐ Still Trying
- ☐ Confused

03 How have others been affected by your health condition?

- ☐ No One Is Affected
- ☐ Haven't Noticed Any Problem
- ☐ They Tell Me To Do Something
- ☐ People Avoid Me

04 **What are you afraid this might be (or beginning) to affect (or will affect)?**

- ☐ Job
- ☐ Kids
- ☐ Future Ability
- ☐ Marriage
- ☐ Self-Esteem
- ☐ Sleep
- ☐ Time
- ☐ Finances
- ☐ Freedom

05 **Are there health conditions you are afraid this might turn into?**

- ☐ Family Health Problems
- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Chronic Fatigue
- ☐ Need Surgery

06 **How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:**

_____

_____

_____

_____

07 **What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:**

1. _____
2. _____
3. _____

08 **What are you most concerned with regarding your problem?**

09 **Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.**

10 **What would be different/better without this problem? Please be specific.**

11 **What do you desire most to get from working with us?**

12 **What would that mean to you?**

WELLNESS EVALUATION

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started

Please check any that apply to you:

Sub-Clinical Symptoms Including:

- ☐ Headaches
- ☐ Migraines

Hormone Imbalance Including:

- ☐ PMS
- ☐ Emotional imbalance

Gastrointestinal Issues Including:

- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:

- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions Including:

- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions Including:

- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions Including:

- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns Including:

- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions Including:

- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results.

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL _____