COLLIER CHIROPRACTIC
BAY CITY

3916 Traxler Court
Bay City, MI 48706
989-391-4788

Last Name:_______________ **First Name:** _______________ **M.I.:**______ **DOB:**_______________

Address: _______________ **Primary Phone:** _______________ (Home/Cell/Work)

City: _______________ **Zip:**_______________ **Secondary Phone:** _______________ (Home/Cell/Work)

SS#:_______________ **Sex:** Male Female **Email:** _______________

Race: American Indian or Alaskan Native / Asian / Black or African American / White or Caucasian / Native Hawaiian or Pacific Islander / Decline to Specify

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Declined to Specify **Preferred Language:** _______________

Relationship Status: Married Single Widowed Partnered Other

How did you hear about our office? _______________

Employment Status

Employment Status: Employed Student Retired Other: _______________ **Occupation:** _______________

Employer/School: _______________ **Phone:** _______________

Address: _______________ **City:** _______________ **Zip:**_______________

Emergency Contact

Name: _______________ **Relationship:** _______________ **Phone:**_______________

Insurance Information

Primary Insurance: _______________ **Policy#:**_______________ **Group#:**_______________

Subscriber Name: _______________ **Relationship:** _______________ **Subscriber DOB:** _______________

Secondary Insurance: _______________ **Policy#:** _______________ **Group#:** _______________

Subscriber Name: _______________ **Relationship:** _______________ **Subscriber DOB:** _______________

Accident Information

Are you here today because of an accident? __________ **Date of accident:** _______________ **Type of accident?** Auto Work Home Other

To whom did you report your accident to? Auto Insurance Employer Worker Comp Other:_______________

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with the policies listed above and assign directly to Collier Chiropractic Bay City all insurance benefits, if any, otherwise payable to me for services rendered. It is my responsibility to know my insurance coverage. I understand that I am financially responsible for all charges whether or not paid by an insurance. I authorize the use of my signature on all insurance submissions. Collier Chiropractic Bay City may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for related services.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please Print Name of Patient, Parent, guardian, or Personal Representative

____
Date

____
Relationship to Patient

MEDICAL HISTORY

Patient Name: ____ **DOB:** ____________________

Reason for visit TODAY: ____

How would you describe your pain? DULL ACHE SHARP SHOOTING THROBBING NUMBNESS BURNING TINGLING

Does your pain travel or shoot anywhere? YES NO **If yes, where?** ______________________________

How long have you had this pain? ________________ **How did it start?** ______________________________

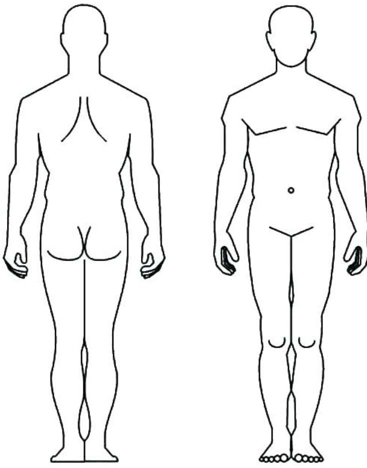
What aggravates your condition? ____________________________ **What helps your condition?** ____________________

How often do you have this pain? __________________ **Is the pain constant or come and go?** ______________________

Is this condition interfering with: WORK SLEEP DAILY ROUTINE OTHER: ______________________________

Have you seen any other provider for this condition? YES NO **If yes, who?** ______________________________

Any diagnostic testing done (X-ray, MRI, CT Scan, UltraSound)? ____________________________ **If yes, when?** __________



Mark an X in the areas you have pain.

Circle ALL that apply:

AIDS/HIV	Hepatitis	Prosthesis
Allergy Shots	Hernia	Psychiatric Care
Anemia	Herniated Disc	Rheumatoid Arthritis
Arthritis	Migraines	Stroke
Asthma	Mono	Thyroid Problems
Bleeding Disorder	Multiple Sclerosis	Tumors, Growths
Cancer	Mumps	Other: ______________
Diabetes	Osteoporosis	____________________
Emphysema	Pacemaker	____________________
Epilepsy	Parkinson’s Disease	____________________
Fractures	Pinched Nerve	____________________
Goiter	Pneumonia	____________________
Heart Disease	Polio	____________________

Circle ALL that apply:

Exercise	Work Activity	Habits	Family
None	Sitting	Smoking – Packs/Day:______________________	Are you Pregnant? __________
Moderate	Standing	Alcohol – Drinks/Week: ____________________	
Daily	Light Labor	Coffee/Caffeine – Cups/Day: ________________	
Heavy	Heavy Labor	High Stress Level – Reason: ________________	

Injuries/Surgeries (Falls, Head Injuries, Broken Bones, Dislocations, Surgeries):

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____

Medications: ____

____

____

Allergies: ____