

Pulver Family Chiropractic
2503 Charlevoix Ave. • Petoskey
231.348.7540
231.348.7621 (fax)
www.pulverchiro.com

New Patient Information

Date : _____ **Name:** _____

D.O.B. : _____ **Email:** _____

Email will be used for health information, information regarding our office, and special promotions.

Address : _____ **City, State, Zip:** _____

Home Phone : _____ **Cell Phone :** _____

Job Duties: _____ **Work Phone:** _____

Spouse : _____ **Children (names/ages) :** _____

Emergency Contact Information: _____

Referred By: Family Friend Phone Book Other :

Which one of our patients shall we thank? _____

Reason you are here: _____

Other Doctors seen for this condition: _____

Who is your general health care practitioner: _____

Contact Information: _____

Do you mind if we send him/her updates on your care? _____

Previous Chiropractor: _____ **Were you satisfied with their care? :** Yes No

Circle any other symptoms you are experiencing or have experienced in the past:

Headaches	Asthma	Allergies	Arthritis	Sinus Problems
Neck Pain	Neck Stiffness	Stomach Pain	Chest Pain	Shoulder/Arm Pain
Sciatica	Numbness	Stress	Hip/Pelvis Pain	Wellness
Upper Back Pain	Middle Back Pain	Lower Back Pain	Other :	

My Symptoms are due to(circle): Auto Accident Work Accident Home Accident
Sports Injury Gradual Onset

Are you Pregnant? Yes No **Due Date:** _____

List all surgeries in the last 5 years : _____

Have you ever had spinal surgery? Yes No

List any serious conditions/other health issues the doctor should be aware of: _____

Please list medication (OTC/Prescription) and supplements you are taking: _____

Office Policies: If I am accepted as a patient at Pulver Family Family Chiropractic, I agree to pay for all services, including services not covered by my insurance company. I also acknowledge, that when I am given explanation of my benefits from the practice, it is not a guarantee of payment. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached the maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe money on my account, there is also a \$150 deposit required to release the x-rays which will be refunded when the x-rays are returned. I also understand that if I came in on a special promotion, including discounted x-rays, the x-rays will not be released until they are paid in full.

Consent to Treat: I understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Dr. Pulver to proceed with any necessary treatments. I have read Dr. Pulver's office policies and consent to treat information, and I agree with them by signing below:

Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Present Health History

When did your present condition begin?

Gradual Onset

Date: _____

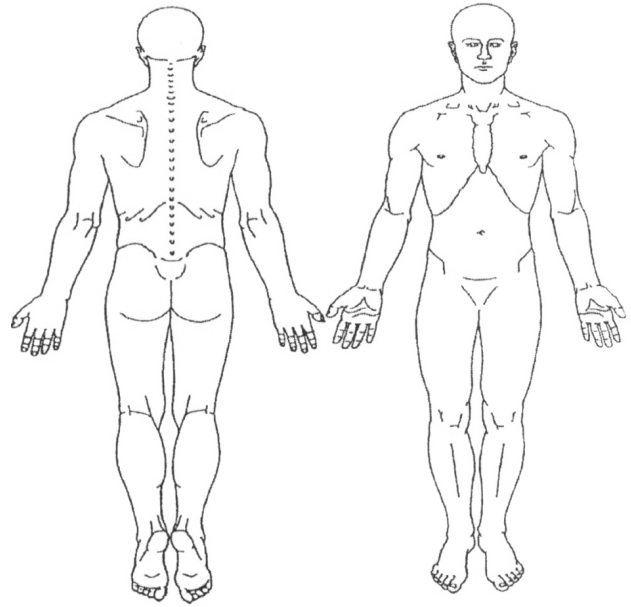
What caused your present condition?

No specific injury

Home Accident

Work Accident

Auto Accident



What happened to cause your present symptoms?

Have you ever had these symptoms before?

No

Yes (date: _____)

Please label the area(s) of today's symptoms

What time of day are your symptoms better?

Morning

Afternoon

Evening

None of the above (constant pain)

What time of day are your symptoms worse?

Morning

Afternoon

Evening

All of the above (constant pain)

What makes your symptoms better?

Rest

Ice packs/Heating pads

Prescription Medications

OTC medications

Other (_____)

What makes your symptoms worse?

Activity (work, repetitive motions)

Ice packs/Heating pads

Driving (or riding) in car

Other (_____)

Patient Health History Worksheet

Significant Past History

Have you ever been hospitalized?

No

Yes (Year: _____ Reason: _____)

Have you had any surgeries?

No

Yes (Year: _____ Reason: _____)

Do you have any significant health problems?

No

Yes (_____)

Family Medical History

Did your father have any health problems?

No

Yes (_____)

Did your mother have any health problems?

No

Yes (_____)

Did your siblings have any health problems?

No

Yes (_____)

Did your grandparents have any health problems?

No

Yes (_____)

Personal History

Do you play any sports or exercise?

No

Yes (_____)

Anything else the doctor should know?

No

Yes (_____)

How many hours do you sleep a night? (_____)

How many hours a week do you work? (_____)

Do you drink alcohol?

No

Yes (How Many: _____)

Please take a few minutes to answer these questions so we can help you get better faster.

Please circle or fill in your response.

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

Medications	Exercise	Vitamins
Emergency Room	Nutrition/Diet	Chiropractic
Routine Medical	Holistic Care	Other : _____

How did that work out for you?

Bad Results	Nothing Changed	Still trying
Some Results	Didn't get worse	Confused
Great Results	Didn't work too long	Other: _____

How have others been affected by your health condition?

No one is affected	They tell me to do something
Haven't noticed any problems	People avoid me

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

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

Are there health conditions you're afraid this might turn into?

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

How has this affected your job, relationships, finances, family, or other activities? _____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc) _____

What are you most concerned with regarding your health? _____

Where do you picture yourself in 5-10 years if it isn't taken care of? _____

What would be different without this issue? _____

What do you desire most from working with us? _____

What's that worth to you? _____