# DAUDE
## FAMILY CHIROPRACTIC

-PLEASE PRINT-

Patient #: _____ Date: _____

Patient Name: (Last, First, Middle Init.) _____

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

Responsible Party: (If Child) _____

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

Best Contact #: _____ C ☐ H ☐ W ☐ 2nd Contact #: _____ C ☐ H ☐ W ☐

Date of Birth: _____ Gender: _____

Ethnicity: Hispanic ☐ Non-Hispanic ☐ Race: Caucasian ☐ African American ☐ Asian ☐ Other _____

Preferred Language: English ☐ Spanish ☐ Other _____

E-mail: _____

Marital Status: S ☐ M ☐ D ☐ W ☐ Number of Children: _____

Employer: _____ Occupation: _____

Are you a current student? _____

How did you hear about us: _____

Insurance Company: _____

Name and date of birth of insured person: _____

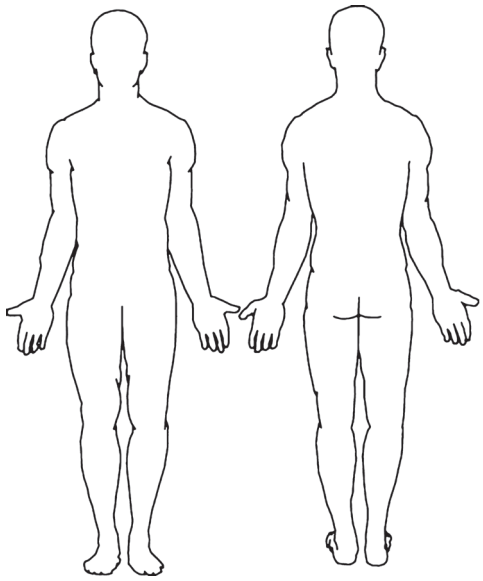
_____

Relationship to insured person: _____

Major Complaint: _____

_____

_____



*Please indicate location of pain on diagram*

# CONDITIONS

**Please check any of the following that give you difficulty or you have recently had:**

| PAST | CURRENT | | PAST | CURRENT | | PAST | CURRENT | | PAST | CURRENT | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Acid Reflux | ☐ | ☐ | Dizziness/Vertigo | ☐ | ☐ | Irritable Bowel Syndrome | ☐ | ☐ | Prostate Trouble |
| ☐ | ☐ | Allergies | ☐ | ☐ | Ear Problems | ☐ | ☐ | Kidney Trouble | ☐ | ☐ | Rheumatoid Arthritis |
| ☐ | ☐ | Anemia | ☐ | ☐ | Eye Problems | ☐ | ☐ | Loss of Smell | ☐ | ☐ | Shortness of Breath |
| ☐ | ☐ | Asthma | ☐ | ☐ | Fainting | ☐ | ☐ | Loss of Taste | ☐ | ☐ | Sinus trouble |
| ☐ | ☐ | Bed Wetting | ☐ | ☐ | Fatigue | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | Skin/hair/nail problems |
| ☐ | ☐ | Bowel Issues | ☐ | ☐ | Hay Fever | ☐ | ☐ | Menstrual Problems | ☐ | ☐ | Sleeping Problems |
| ☐ | ☐ | Cancer | ☐ | ☐ | Headaches | ☐ | ☐ | M.S. | ☐ | ☐ | Spinal curvature/Scoliosis |
| ☐ | ☐ | Celiac Disease | ☐ | ☐ | Heartburn | ☐ | ☐ | Nervousness | ☐ | ☐ | Stroke |
| ☐ | ☐ | Chest Pain | ☐ | ☐ | Heart Attack | ☐ | ☐ | Numb arms/hands | ☐ | ☐ | Swollen Extremities |
| ☐ | ☐ | Cold hand/fingers | ☐ | ☐ | Hernia | ☐ | ☐ | Numb legs/feet | ☐ | ☐ | Thyroid Trouble |
| ☐ | ☐ | Cold Feet | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Osteopenia | ☐ | ☐ | Ulcers |
| ☐ | ☐ | Constipation | ☐ | ☐ | High Cholesterol | ☐ | ☐ | Osteoporosis | ☐ | ☐ | Ulcerative Colitis |
| ☐ | ☐ | Crohn's Disease | ☐ | ☐ | Hip Pain | ☐ | ☐ | Painful Joints | ☐ | ☐ | Urinary Problems |
| ☐ | ☐ | Depression | ☐ | ☐ | Infertility | ☐ | ☐ | Pins/Needles- arm/hand | ☐ | ☐ | Weight Change (unplanned) |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Irritability | ☐ | ☐ | Pins/Needles- leg/foot | | | |

## PAST MEDICAL HISTORY

- Have you had chiropractic care before? If so, when:_____
- Have you had these symptoms before? If so, when:_____
- Are your symptoms: **Improving** **About the Same** **Comes and Goes** **Getting Worse**
- Any major falls, accidents (including auto) or injuries?_____

  _____
- List any surgeries:_____
- List any prescription medications:_____

  _____
- List any supplements/over the counter meds: _____

  _____
- Allergies to any medications? If yes, list and what reaction: _____

  _____
- Do you smoke? ☐ Yes ☐ No Have you ever smoked? ☐ Yes ☐ No
- If yes, what type and how much? _____
- What is your exercise activity level: **None** **Light** **Moderate** **Strenuous**
- Stress Level: **Mild** **Moderate** **Extreme**
- Physical Activities at Work: **Sitting 50% or more** **Repetitive Motions** **Light Labor** **Manual Labor** **Heavy Labor**

## FAMILY HISTORY

**Please List:** FATHER, MOTHER, SIBLING, PATERNAL GRANDFATHER, PATERNAL GRANDMOTHER, MATERNAL GRANDFATHER , MATERNAL GRANDMOTHER, DECEASED

- Aneurysm _____
- Arthritis _____
- Back problems _____
- Cancer _____
- Diabetes _____
- Headaches/Migraines _____
- Heart Disease _____
- High Blood Pressure _____
- Osteoporosis _____
- Scoliosis _____
- Stroke _____
- Ulcers _____

## FEMALES ONLY

To the best of your knowledge, are you currently suspected or confirmed pregnant? YES ☐ NO ☐

## ALL PATIENTS PLEASE SIGN!

I UNDERSTAND THAT MY RECORDS ARE KEPT CONFIDENTIAL AND I CERTIFY THAT THE INFORMATION I HAVE PROVIDED HERE IS TRUE TO THE BEST OF MY KNOWLEDGE:

X: _____ _____

Patient Signature Date

### Assignment of Benefits:

I understand and agree that I am ultimately responsible for payment. I hereby authorize and direct my insurance company and/or attorney to pay by check or direct deposit to Daude Family Chiropractic, PC, 55185 Shelby Rd, Shelby Twp, MI 48316. Further, I agree to pay the difference, if any, between the total amount of charges and the amount paid by my insurance and/or attorney. I also agree to pay the full amount of charges should they not be covered by my policy or if my insurance company or attorney refuse payment. **THIS IS A DRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Patient/Guardian Signature _____

Witness_____

### Office Financial Policy

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at time of service.
- Patient is responsible for any returned check fees
- Unpaid balances after 3 months are forwarded to Transworld Systems, Inc with an additional $16.50 fee.
- We participate in most insurance plans, however we require that the guarantor, the person who is financially responsible, is personally liable for all balance not covered by insurance. It is your responsibility to understand and comply with any Pre-determination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies.

Signature _____ Date _____