

Loranger Family Chiropractic Center, P.C.
125 W. Columbia Ave.
Belleville, MI 48111
(734)697-4244 Office • (734) 697-8102 Fax

Date: _____
Name: _____ S.S.#: _____
Address: _____ City _____
State: _____ Zip: _____ Date of Birth: _____ Age: _____
Home Phone: _____ Work Phone: _____ Ext. _____
Cell Phone: _____
Marital Status: S M D W Spouse Name: _____
Children: Yes No Names and Ages: _____

Employer: _____
May we contact you at work? Yes No Emergency Basis Only

E-Mail Address: _____
Would you like to receive newsletters and other E-Mail from our office? Yes No

Referred By: _____
Purpose of this appointment (Major Complaint) _____

Date symptoms appeared: _____ How Long: _____
Have you ever been under chiropractic care? Y N When: _____ Who: _____
Is this condition getting progressively worse? Y N Constant Comes and Goes
Is your condition a result of: Employment Auto Accident Personal Injury Other _____
List any accidents, injuries or surgeries in the past year: _____

Past 10 years: _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT

Name of person responsible for payment: _____ Relation: _____
Are you insured? Yes No Company: _____
Policy number: _____ Group#: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Loranger Family Chiropractic Center will help prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount is to be paid directly to this office. However, I clearly understand and agree that all services rendered to me are ultimately my responsibility for payment.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed. It is understood and agreed that the X-Ray negatives will remain property of this office. They may be seen at any time while a patient of this office.

Signature _____ Date: _____

HAVE YOU EVER SUFFERED FROM:

- | | | | | |
|---|---|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Poor posture | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Itching | <input type="checkbox"/> Auto-Immune |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Spinal Curvature/Scoliosis | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Drug dependancecy |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Colon trouble | <input type="checkbox"/> Sinus infection | <input type="checkbox"/> Kidney infection/stone | <input type="checkbox"/> Upper respiratory |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Digestive difficulties | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Cramps or backache | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pain over heart | <input type="checkbox"/> Excessive menstrual flow | <input type="checkbox"/> Herniated disk |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Nausea | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Irregular cycle | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Colds | <input type="checkbox"/> Slow heart beat | <input type="checkbox"/> Lumps in breast | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Deafness | <input type="checkbox"/> Anemia | <input type="checkbox"/> Alcoholism | |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Ear noises | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Swelling of ankles | <input type="checkbox"/> Cancer | |

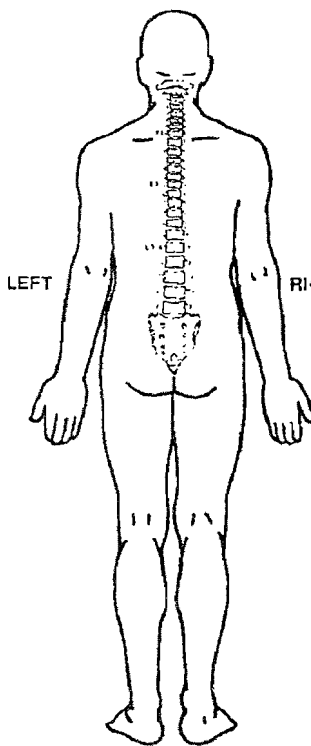
Tingling or numbness in: Shoulders (right/left) Arms (right/left) Elbows (right/left)
 Hands (right/left) Hips (right/left) Legs (right/left) Knees (right/left) Feet (right/left)

Are you wearing: Heel lifts Sole lifts Inner soles Arch supports Orthotics

Medications you now take: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Antidepressants
 Insulin Aspirin/Similar Other

Are you pregnant? Yes No Date of last menstrual cycle: _____

Are you trying to become pregnant? Yes No How long? _____



LEFT RIGHT

SEVERITY OF PAIN
 List region of pain and circle severity number. [1 = least, 10 = greatest]

ex. Neck

1 2 3 **4** 5 6 7 8 9 10

MARK PAIN AREA

+++ Burning
 000 Stabbing
 --- Sharp
 ||| Constant

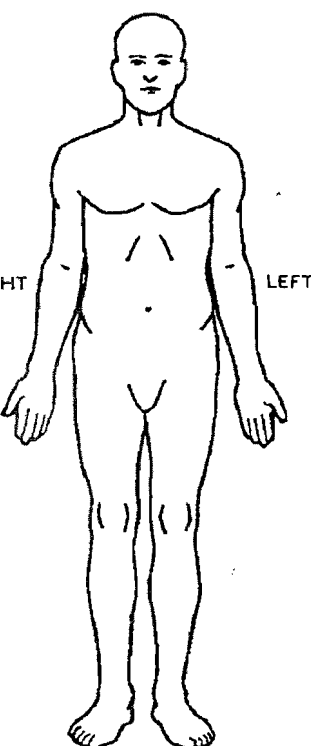
1. _____
 1 2 3 4 5 6 7 8 9 10

2. _____
 1 2 3 4 5 6 7 8 9 10

3. _____
 1 2 3 4 5 6 7 8 9 10

4. _____
 1 2 3 4 5 6 7 8 9 10

5. _____
 1 2 3 4 5 6 7 8 9 10



RIGHT LEFT

Please mark area of pain on the drawing using the code listed above.