DR. AMANDA APFELBLAT
Chiropractor

HEALTH QUESTIONNAIRE

—PLEASE PRINT—

MICHIGAN CHIROPRACTIC SPECIALISTS
a professional corporation

30900 Ford Road, Suite C,
Garden City, MI 48135
Phone (734) 838-0353
Fax (734) 838-0359

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU, PLEASE COMPLETE ALL QUESTIONS

1. Name	2. Phone	3. Date
3. Complete address (include city, state and zip)	4. Date of birth	5. Age

6. ☐ Married/Spouses name ☐ Widowed ☐ Single ☐ Divorced

7. # of children Names & Ages

8. Occupation 9. Your Employer Work phone

9a. Your Social Security No. 9b. Spouses Social Security No.

9c. Spouse's Employer 9d. Spouse's Work Phone

9e. Your Email 9f. Primary Care Physician

10. What are your major complaints?

A.

B.

C.

How long has it been bothering you?
A. B. C.

Has it bothered you before?
A. B. C.

11. Referred by	12. Have you had chiropractic care before? ☐ Yes Where? ☐ No	13. Do you have health insurance ☐ Yes Company? ☐ No
14. Are you on Medicare? ☐ Yes Medicare# ☐ No	15. Are you on Medicaid (ADC), etc.? ☐ Yes Medicaid # ☐ No	16. Could you be pregnant? ☐ Yes ☐ No

17. Please indicate if you are here for care because of: ☐ an on the job injury ☐ an auto accident ☐ home injury

Date Injured	Insurance Company	Attorney's Name (if any)	Attorney's Address

	MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY
18. Have you ever had any falls, auto accidents, or injuries? ☐ Yes Please describe ☐ No			
19. Have you ever had surgery? ☐ Yes Please explain. ☐ No			
20. Are you presently taking medications or vitamins? ☐ Yes Please list. ☐ No			

21. Have you ever taken these tests?
MRI ☐ No ☐ Yes Date taken: CT Scan ☐ No ☐ Yes Date taken:

22. Please check any of the following that give you difficulty or you have had recently ☐

- ☐ Headaches 784.0
- ☐ Shooting head pains 784.0
- ☐ Sinus trouble 473.9
- ☐ Loss of smell 781.1
- ☐ Allergies 995.3
- ☐ Hay fever 477.8
- ☐ Asthma 493.9
- ☐ Loss of taste 781.1
- ☐ Inflammation of throat 462.0
- ☐ Thyroid trouble 245.9
- ☐ Twitching of face 351.9
- ☐ Loss of memory
- ☐ Fatigue 780.7
- ☐ Depression 311.0
- ☐ Dizziness 780.4
- ☐ Spinal curvature 737.43
- ☐ Chest pain 786.5
- ☐ Fainting 780.2
- ☐ Loss of balance 781.2
- ☐ Ringing in ears 388.3
- ☐ Blurred vision 368.0
- ☐ Lights bother eyes 368.13
- ☐ Neck pain 723.1
- ☐ Muscle spasms in neck 781.0
- ☐ Grinding in neck 719.68
- ☐ Tightness of shoulders & arms 728.85
- ☐ Pain in shoulders & arms 719.4
- ☐ Pins & needles in arms & hands 782.0
- ☐ Cold hands 782.0.
- ☐ Numbness In arms/hands 782.0
- ☐ Cold hand/fingers 782.0
- ☐ Tonsillitis 784.0
- ☐ Prostate trouble 601.4
- ☐ Ulcers 534.9
- ☐ Numbness legs or feet 782.0
- ☐ Constipation 564.0
- ☐ Kidney trouble 593.9
- ☐ Menstrual cramps/pain 625.3
- ☐ Menstrual/Irregularity 626.4
- ☐ Diabetes 250.0
- ☐ Sleeping problems 780.5
- ☐ Painful joints 719.4
- ☐ Swollen joints 719.0
- ☐ Pins & needles in legs 782.0
- ☐ Swollen ankles 782.3
- ☐ Cold feet 782.0
- ☐ Pain in legs & feet 719.46
- ☐ Hip pain 719.45
- ☐ Shortness of breath 786.09
- ☐ Mid-back pain 724.1
- ☐ Heart attacks 410.9
- ☐ High blood pressure 401.9
- ☐ Low blood pressure 458.9
- ☐ Anemia 285.9
- ☐ Stomach trouble 789.0.
- ☐ Nerves and nervousness 799.2
- ☐ Inner tension 799.2
- ☐ Irritability 799.2
- ☐ Gall bladder trouble 575.9
- ☐ Indigestion 536.8
- ☐ Intestinal gas 787.3
- ☐ Low back pain 724.2
- ☐ Hernia 550.01
- ☐ Stroke 436.0
- ☐ Bed wetting 788.3

23. Please give details of any family health conditions (e.g. hypertension, heart problems, diabetes, back problems, cancer, etc).

Name:	Relation:	Past/Present Health Problems

Assignment

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient Signature _____ Date _____

Release of Information

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and hereby release this clinic of any consequence thereof.

Patient Signature _____ Date _____

Financial Responsibility

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, copayment and any services rejected by my insurance company.

Patient Signature _____ Date _____

Guardian/Parent Signature authorizing care _____ Date _____

DO NOT WRITE BELOW THIS LINE - FOR DOCTOR'S USE ONLY

COMMENTS _____