WELCOME

Aamodt Chiropractic Clinic PC
1805 44th Street S.E., Grand Rapids, MI 49508
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"Quality…not Quantity Care"

1 About You:

Full Name:______________________ Today's Date____/____/_______

Preferred Name: _______________DOB: _____/_____/_________ Current Age: _______ Male ☐, Female ☐

Home Street Address:_______________________________________

City: ______________________ State:________ Zip:____________

Home Phone: (_____)______-__________ Cell Phone: (_____)______-__________

Email:______________________________

Do you use Social Networks?
Facebook ☐ Twitter ☐
Other: _____________

~Check if a Full Time Student ☐ ~Check if Active Duty Military ☐ ~Check if a Minor (under 18) ☐

~Check if pregnant ☐ ~Check if on SSI Disability ☐ Primary Physician Name: ________________

Marital Status: Married ☐ Single ☐ Other ☐ Spouse Name (if applicable): ________________

Emergency Contact Person:_____________________ Relationship:____________ Phone____________

Would you like to receive our newsletter by email (coupons & discount offers)? Yes ☐, No Thanks ☐

2 About Your Employer:

Employed by:_______________________________________

Work Address: ________________________City:________________Zip:__________

Work Phone: (____)______-________ (call my Cell ☐) Main Employment: Full time ☐ Part time ☐ None ☐

Your primary job description?______________________________ Years employed here? ______

Second Employer, if any?_____________________ How many ***Total*** hours do you work:_________

If you are a student, where do you attend? ____________________________________

3 About Insurance:

Will you be using insurance? Yes ☐ No ☐ Not Sure ☐ Uninsured ☐

Insurance Company Info: ____

Is this injury caused by: ☐ Work ☐ Auto Injury ☐ Not Sure ☐ Other Injury ☐ ________________

~***If work related*** have you notified your employer? Yes ☐ No ☐ Name of Supervisor:________________

~***If auto related*** will you file a claim for benefits? Yes ☐ No ☐ Auto Info:____________________

Who is the Policy Holder? Myself ☐ (Let us photocopy your insurance card)

(complete boxes below if someone else insures you) My Spouse ☐ My Parent ☐ I also have Secondary Insurance ☐

INSURANCE IS THROUGH MY SPOUSE OR PARENT	SECONDARY INSURANCE ONLY
*(Complete **ONLY** if Spouse or Parent is the policy holder)*	*(Complete **ONLY** if you also have a 2nd Insurance)*
Policy Holder Name:_______________________	Spouse Name:_______________________
Policy Holder DOB: ____/____/_________ (mm/dd/yyyy)	Spouse DOB: ____/____/__________ (mm/dd/yyyy)
Their Employer: _________________________	Their Employer: _________________________
COPY OF CARD NEEDED	**COPY OF CARD NEEDED**

4 Related Information:

Were you referred to us by someone? _______________________

Chose us by? Location ☐ Phone book ☐ Internet Search ☐ Our website ☐ Friend/Relative ☐ Other:______________

Have you had spinal x-rays in the past 2 years? Yes ☐ No ☐ Who has them? ____________________

Have you treated with prior chiropractor(s)? Yes ☐ No ☐ Who? ________________________

What other Professionals, if any, have you seen for this? ___________________________

____

Form Name: ACCInitialPatientEntryFormPg1

Aamodt Chiropractic Clinic, 1805 44th Street S.E., Grand Rapids, MI 49508 (pg 2)

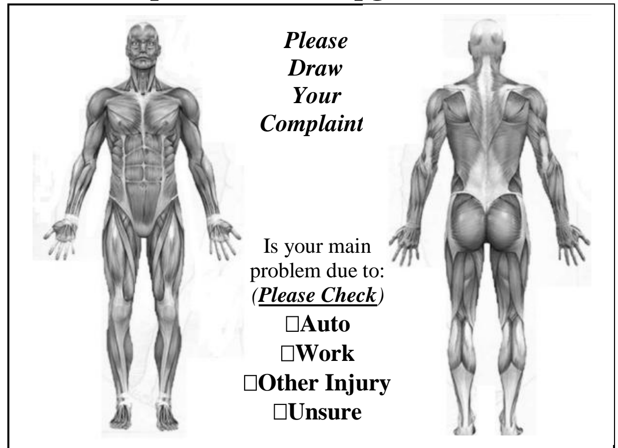
Complaints: Please list your complaints in order of your concern:

1. ____
2. ____
3. ____
4. ____
5. ____

On a pain scale of 1 to 10, please rate your complaints from above:

Complaint #1 from above: (mild) 1---2---3---4---5---6---7---8---9---10 (max)
Complaint #2 from above: (mild) 1---2---3---4---5---6---7---8---9---10 (max)
Complaint #3 from above: (mild) 1---2---3---4---5---6---7---8---9---10 (max)
Complaint #4 from above: (mild) 1---2---3---4---5---6---7---8---9---10 (max)
Complaint #5 from above: (mild) 1---2---3---4---5---6---7---8---9---10 (max)

(select the typical or "average" level of your pain)



When did your complaints/symptoms start: ________________________ Are complaints ☐ Constant ☐ Frequent ☐ Occasional ☐ Infrequent

Describe how it started/evolved: ____

Have you noticed your problem getting: ☐ Better ☐ Worse ☐ Unchanged ☐ Unsure ____________________________

Have you had this problem before? ☐ No ☐ Yes: When?______________________ Had it resolved before?: ☐No ☐ Yes

List current medications if any? ____

Any other tests/findings related to your complaint?: ☐MRI ☐XRay ☐CTScan Other: ____________________________

Does anything make you feel better? ☐ No ☐ Yes Describe: ____________________________

Does anything make you feel worse? ☐ No ☐ Yes Describe: ____________________________

Health History: Do you have a history of problems with the following conditions or categories? (Check all that apply with brief details please)

☐ Anemia (low iron blood)	☐ Asthma (wheezing)	☐ Diabetes	☐ Mitral Valve Prolapse	☐ Allergic to: ______________
☐ Heart Trouble	☐ Dizziness	☐ Cancer	☐ Fainting	☐ Confusion or Memory Loss
☐ Arm Problems	☐ Numbness/Tingling	☐ Liver Trouble	☐ Low Bone Density	☐ Joint Replacement: ______________
☐ Leg Problems	☐ Unexplained Fatigue	☐ Ulcers/Digestive Issues	☐ Neck Problem	☐ Past Pregnancies: (years) __________
☐ Stroke or TIA	☐ High Blood Pressure	☐ Substance Abuse	☐ Mid Back Problems	☐ Currently Pregnant
☐ Frequent Headaches	☐ Headaches/Migraines	☐ Herniated Disc	☐ Low Back Problems	☐ Past Hospitalizations: ____________
☐ Epilepsy (fits, seizures)	☐ Anxiety/Depression	☐ Fractures (Body Regions): ______________		

☐ Spinal surgery Body Region:____________________ Year(s): __________ Surgeon(s): ________________ Outcome?: ____________________

☐ Other surgery(ies)________________________________ ☐ Other Health History?: ______________________________

Spinal Care History:

Have you ever been to a Chiropractor before: ☐ No ☐ Yes: Who/Where? ___________________What was your reason for past Chiropractic Care: ____________________ Time Frame of Care? ______________Was your past chiropractic care an overall positive experience? ☐ No ☐ Yes ☐ Other: ______________________________

What's your bed? ☐ Spring ☐ Waterbed ☐ Foam ☐ Air ☐ Other: ___________ Is your bed comfortable? ☐ No ☐ Yes ☐ Unsure

Do you currently use: ☐ Nutritionals ☐ Cane/Crutch ☐ Orthopedic Neck Pillow ☐ Foot Supports ☐ Back Brace ☐ Tobacco ☐ Alcohol

Please summarize any past injuries in the following categories:

Been involved in auto accidents….. ☐ No ☐ Yes ☐ Describe: ______________________________
Been diagnosed with birth defect… ☐ No ☐ Yes ☐ Describe: ______________________________
Had previous back/spinal injury…. ☐ No ☐ Yes ☐ Describe: ______________________________
Had bad reaction to chiro care…… ☐ No ☐ Yes ☐ Describe: ______________________________
Lost work due to back problems… ☐ No ☐ Yes ☐ Describe: ______________________________
Do you have other health issues… ☐ No ☐ Yes ☐ Describe: ______________________________