

**CHIROPRACTIC NATURAL HEALTH ASSOCIATES**  
15831 12 Mile Road, 3 blocks West of Greenfield. Southfield, MI 48076-3011  
(248) 559-6763 fax (248) 559-6774 www.DrBorn.com

Chart #: \_\_\_\_\_

**Please answer each question fully. If it doesn't apply, put N/A.**

Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_ Number of Children: \_\_\_\_\_

Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Referred By: \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Business Phone: (\_\_\_\_\_) \_\_\_\_\_

Employed By: \_\_\_\_\_

Single  Married  Divorced  Separated  Widowed Spouse's Name: \_\_\_\_\_

Have you received Chiropractic care before?  No  Yes - Where and when? \_\_\_\_\_

Do you have health insurance?  No  Yes - What company? \_\_\_\_\_

**CURRENT CONDITIONS**

Have you had a recent slip, fall, accident or other injury?  No  Yes (Explain) \_\_\_\_\_

Have you been in an automobile accident?  No  Yes - When? \_\_\_\_\_

Is this a reported Workmen's Compensation injury claim?  No  Yes

What is your primary concern today: \_\_\_\_\_

Please list other doctors seen for this condition: \_\_\_\_\_

Were X-rays, MRI or CAT Scan taken?  No  Yes - Date & Place: \_\_\_\_\_

List diagnosis and types of treatments for this condition: \_\_\_\_\_

When did this begin? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (actual date to your best recollection)

When did this most recently flare up? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Would you say this is getting better or worse since the most recent date? \_\_\_\_\_

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Describe your pain or symptoms: \_\_\_\_\_

What makes this feel better? \_\_\_\_\_

What makes this feel worse? \_\_\_\_\_

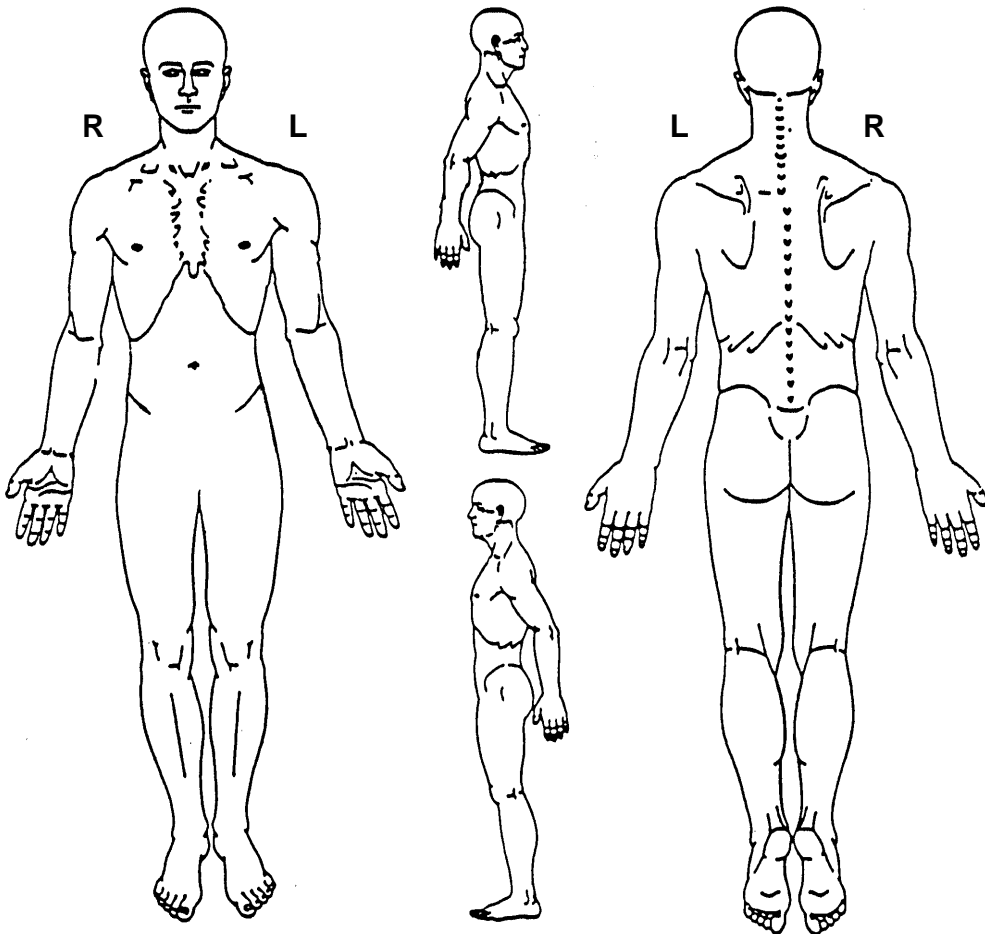
Does it stay in one place?  Yes  No - what other parts of your body does it travel to? \_\_\_\_\_

On a scale of 1 to 10, with 1 being no symptoms, and 10 being the worst pain imaginable, please rate your pain or symptoms now: \_\_\_\_\_. Please rate your pain or symptoms at their worst: \_\_\_\_\_

What does this pain prevent you from doing? (positions, actions, etc.) \_\_\_\_\_

Is the pain constant (24 hours a day with no break at all)?  Yes  No - Please explain when it hurts: \_\_\_\_\_

**Please color everywhere you feel pain or symptoms:**



Please list all the medications you currently take and what you take them for: \_\_\_\_\_

**FOR WOMEN:** When was your last menstrual cycle? \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Birth control method: \_\_\_\_\_ Is it possible you're pregnant? \_\_\_\_\_

**FOR MEN:** When was your last prostate exam? \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Results: \_\_\_\_\_ Have you had any recent urinary changes? \_\_\_\_\_

**HEALTH HISTORY**

Childhood Diseases:  Mumps  Measles  Chicken Pox  Other: \_\_\_\_\_

Please list operations, surgeries, fractures, &/or diseases you have had (with the approximate dates):

**FAMILY HISTORY**

Father: Living?  No  Yes – Age? \_\_\_\_ Mother: Living?  No  Yes – Age? \_\_\_\_

Nearest relative's name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

How are you related?: \_\_\_\_\_

Does your immediate family have a history of any of the following:

- Cancer  Tuberculosis  Heart diseases  Diabetes  Asthma  Arthritis  Lung Disease
- Mental Illnesses  Kidney Disease  Liver Disease  Other \_\_\_\_\_

**PLEASE READ CAREFULLY:**

If you have insurance coverage, we will make every effort to collect from them, however, it should be understood that the patient (or guardian) is ultimately responsible for payment of all charges incurred in this office.

- I understand that the provider's charge may exceed the insurance payment, and if greater than such payment, I will be responsible for the balance.
- I also understand that all treatments, X-rays, and examinations are to be paid for as they are received unless definite financial arrangements have been made in advance.
- I authorize the release of any medical information necessary to process the insurance claim and request payment of benefits to the provider who accepts my case.

\_\_\_\_\_  
Patient Signature (or guardian)

\_\_\_\_\_  
Date