

## Welcome to Fruitport Chiropractic Center

Our mission at Fruitport Chiropractic Center is to help you achieve all of your health goals and needs. Whether your main reason for seeing us to get out of pain, increase your energy, lose weight or simply take your health to the next level, we are here to provide you with the tools and knowledge to help you on your journey to optimal health.

The first step in the process is to establish your current state of health and the overall function of your body. In order for us to assess this and understand the root cause of your symptoms, we will take you through a series of non-invasive examinations on your initial visit. This includes a full case history, nerve and muscle tests, postural analysis, functional movement assessment, bioimpedance analysis, spinal x-rays and blood pressure tests.

There are a few simple steps for you to follow prior to your examination:

- No alcohol within 24 hours
- No exercise for 4 hours
- Avoid caffeine or food for 4 hours
- Consume 2-4 glasses of water within 2 hours

On the day of your visit, we ask that you wear comfortable clothing you can easily move in. We will take a postural photo of you, so please avoid multiple layers or bulky clothing. Full tights and pantyhose will need to be removed.

At your initial visit, please bring all completed paperwork (6 pages total) and any previous X-ray or MRI reports, or recent blood work with you so we may refer to these during our case history.

Your initial assessment will take between 45-60 minutes. Please allow sufficient time for your appointment. If you have time constraints, contact our front desk prior to your visit.

### **PLEASE NOTE:**

We have a 24-hour cancellation policy where the agreed upon initial exam fee will be charged if prior notice has not been given. If you are running late please contact the front desk at 231-865-6545. Late arrivals do run the risk of requiring a rescheduled appointment.

## GENERAL INFORMATION

Please fill out the forms *completely and accurately* to the best of your ability so we can quickly get you on the road to health.

Today's Date: \_\_\_\_\_ Social Security Number (SSN): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle Initial

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email (to enable the doctors to communicate with you): \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Preferred method of communication (select one): Email \_\_\_\_\_ Text \_\_\_\_\_ (Carrier's Name: \_\_\_\_\_)

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Are you: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Partnered for \_\_\_ years Minor \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Ethnicity (select one): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Race (select one): American Indian or Alaskan Native / Asian / Black or African American / White (Caucasian)  
Native Hawaiian or Pacific Islander / Other / Decline to Answer

Your Employer or School: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse's Birthdate: \_\_\_\_\_ Employer: \_\_\_\_\_

## EMERGENCY CONTACT

Name of Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## ACCIDENT INFORMATION

Is your condition due to an accident? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Type of Accident: Auto \_\_\_\_\_ Work \_\_\_\_\_ Home \_\_\_\_\_ Other (please describe) \_\_\_\_\_

**INSURANCE INFORMATION**

Please complete this section regardless of your referral source (including non-referral external workshops). We are happy to verify your insurance coverage and provide your benefits information to you. We will NEVER bill your insurance without your permission.

Who is responsible for this account? \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**ASSIGNMENT AND RELEASE:**

I certify that I, and / or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to Drs. Andrew Szatkowski, and / or Steven Szatkowski, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative	Date
Please print name of above signature	Relationship to Patient

**X-RAY CONSENT**

I hereby give my consent to the Fruitport Chiropractic Center and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant. I have read and understood all the above information.

Signature of Patient, Parent, Guardian or Personal Representative	Date
Please print name of above signature	Relationship to Patient

**CLINICAL SUMMARY (a required EMR question)**

\_\_\_\_\_ I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care).

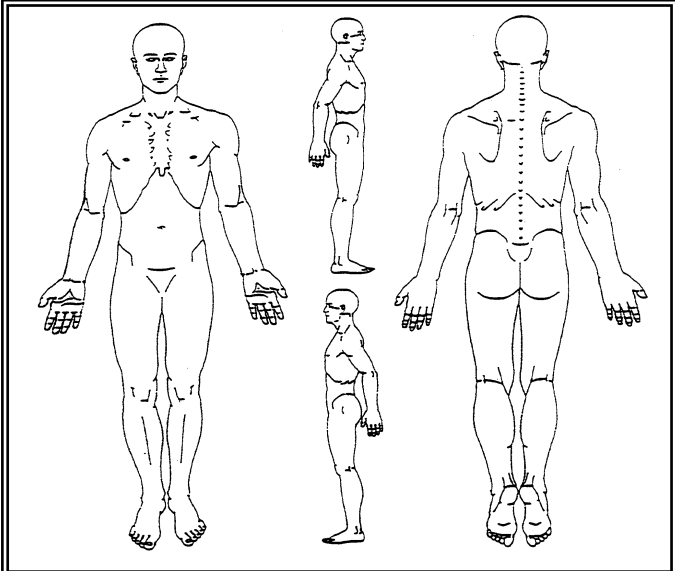
**YOUR VISIT**

We appreciate you choosing our office. Is there anyone we can thank for referring you? \_\_\_\_\_

Please indicate the main reason you are seeing us today: \_\_\_\_\_

If you are seeing us for a pain-related issue, USE THE SYMBOLS on the image to the right to show the type of pain you feel in each location.

- |                 |                     |
|-----------------|---------------------|
| X X X X X X X X | DULL / ACHY         |
| / / / / / / / / | SHARP / STABBING    |
| o o o o o o o o | NUMBNESS / TINGLING |
| s s s s s s s s | STIFF/TIGHT         |
| - - - - -       | BURNING             |



Using the pain scale to the right, CIRCLE the pain level you experience when your problem is at its very worst.

- 0 = No Pain.** No Discomfort
- 1 = Minimal Discomfort.** Minor stiffness or tightness.
- 2 = Discomfort.** Stiff, tight, sore. Muscle fatigue.
- 3 = Minimal Pain.** More than just sore. Uncomfortable.
- 4 = Mild Pain.** Noticeable pain but tolerable.
- 5 = Moderate Pain.** Aggravating. Still allows movement.
- 6 = Strong Pain.** Quite aggravating. Movement slightly limited.
- 7 = Very Strong Pain.** Very aggravating. Movement definitely limited.
- 8 = Very, Very Strong Pain.** Extremely aggravating. Movement very limited.
- 9 = Severe Pain.** Brings tears. Almost impossible to move.
- 10 = Excruciating Pain.** Agony. Unbearable. Cannot move. ER.

Is there any radiating pain into the arms or legs? Yes \_\_\_\_\_ No \_\_\_\_\_ Is there any numbness or tingling? Yes \_\_\_\_\_ No \_\_\_\_\_

How often do you experience your problem? (Please indicate for each of the body locations, if applicable)

Constant (75-100% of the time): \_\_\_\_\_ Frequent (50-75% of the time): \_\_\_\_\_  
 Occasional (25-50% of the time): \_\_\_\_\_ Intermittent (0-25% of the time): \_\_\_\_\_

List any MDs or Chiropractors you've already seen for this problem: \_\_\_\_\_

What tests have you already had for this problem? X-rays \_\_\_\_\_ MRI \_\_\_\_\_ Myelogram \_\_\_\_\_ EMG / NCV \_\_\_\_\_ None \_\_\_\_\_  
 Other (please describe) \_\_\_\_\_

What makes your problem worse? Sitting \_\_\_\_\_ Standing \_\_\_\_\_ Changing Position \_\_\_\_\_ Walking \_\_\_\_\_ Bending \_\_\_\_\_  
 Lifting \_\_\_\_\_ Twisting \_\_\_\_\_ Reaching \_\_\_\_\_ Driving \_\_\_\_\_ Sleeping \_\_\_\_\_ Sneeze / Cough \_\_\_\_\_ Computer Work \_\_\_\_\_  
 Telephone \_\_\_\_\_ Going from Sit to Stand \_\_\_\_\_ Other (please describe) \_\_\_\_\_

## MEDICAL HISTORY

Please list any significant conditions you've been diagnosed with or have been treated for over the course of your life: \_\_\_\_\_

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Please list any surgeries you have had over the course of your life: \_\_\_\_\_

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Are you allergic to any medications? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list: \_\_\_\_\_

List any medications, herbs or supplements you are taking and the reason for their use: \_\_\_\_\_

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## FAMILY HISTORY

Mother: Living \_\_\_\_\_ Deceased \_\_\_\_\_ List any medical problems: \_\_\_\_\_

Father: Living \_\_\_\_\_ Deceased \_\_\_\_\_ List any medical problems: \_\_\_\_\_

List any problems common to your family: Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart disease \_\_\_\_\_ High blood pressure \_\_\_\_\_

Stroke          Arthritis          Scoliosis          Thyroid disease          Osteoporosis          Other (describe)

## SOCIAL HISTORY

Are you: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Partnered for \_\_\_\_\_ years

Do you have any children? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much and how often? \_\_\_\_\_

Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how much, how often and how long? \_\_\_\_\_

Are you currently employed? Yes \_\_\_\_\_ No \_\_\_\_\_

Who is your current employer? \_\_\_\_\_ How long have you been at this job? \_\_\_\_\_

What do you do most of the day in your job postures, positions and repetitive movements? \_\_\_\_\_

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On a scale of 0-10 (0 = Worst and 10 = Best) rate how well you think you are doing with the following:

Exercise \_\_\_\_\_ Sleep \_\_\_\_\_ Diet \_\_\_\_\_ Stress Level \_\_\_\_\_ Water Intake \_\_\_\_\_ Energy Level \_\_\_\_\_

## REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days:

- 0 = Never have this symptom
- 1 = Occasionally have this symptom, effect not severe
- 2 = Occasionally have this symptom, effect is severe
- 3 = Frequently have this symptom, effect not severe
- 4 = Frequently have this symptom, effect is severe

<b>Head:</b> <input type="checkbox"/> Headaches <input type="checkbox"/> Faintness <input type="checkbox"/> Dizziness <input type="checkbox"/> Insomnia	<b>Energy / Activity:</b> <input type="checkbox"/> Fatigue / Sluggishness <input type="checkbox"/> Apathy / Lethargy <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Restlessness	<b>Lungs:</b> <input type="checkbox"/> Chest Congestion <input type="checkbox"/> Asthma, Bronchitis <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Difficulty Breathing
<b>Eyes:</b> <input type="checkbox"/> Watery or Itchy Eyes <input type="checkbox"/> Swollen, Red or Sticky Eyelids <input type="checkbox"/> Bags or Dark Circles Under Eyes <input type="checkbox"/> Blurred or Tunnel Vision (not including near or far sightedness)	<b>Weight:</b> <input type="checkbox"/> Binge Eating / Drinking <input type="checkbox"/> Craving Certain Foods <input type="checkbox"/> Excessive Weight <input type="checkbox"/> Compulsive Eating <input type="checkbox"/> Water Retention <input type="checkbox"/> Underweight	<b>Heart:</b> <input type="checkbox"/> Irregular or Skipped Heartbeat <input type="checkbox"/> Rapid or Pounding Heartbeat <input type="checkbox"/> Chest Pain
<b>Ears:</b> <input type="checkbox"/> Itchy Ears <input type="checkbox"/> Earaches, Ear Infections <input type="checkbox"/> Drainage from Ear <input type="checkbox"/> Ringing in Ears, Hearing Loss	<b>Emotions:</b> <input type="checkbox"/> Mood Swings <input type="checkbox"/> Anxiety / Fear / Nervousness <input type="checkbox"/> Anger / Irritability / Aggressiveness <input type="checkbox"/> Depression	<b>Digestive Tract:</b> <input type="checkbox"/> Nausea, Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating Feeling <input type="checkbox"/> Belching, Passing Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Intestinal / Stomach Pain
<b>Nose:</b> <input type="checkbox"/> Stuffy Nose <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Hay Fever <input type="checkbox"/> Sneezing Attacks <input type="checkbox"/> Excessive Mucus Formation	<b>Mind:</b> <input type="checkbox"/> Poor Memory <input type="checkbox"/> Confusion, Poor Comprehension <input type="checkbox"/> Poor Concentration <input type="checkbox"/> Poor Physical Condition <input type="checkbox"/> Difficulty Making Decisions <input type="checkbox"/> Stuttering or Stammering <input type="checkbox"/> Slurred Speech	<b>Mouth and Throat:</b> <input type="checkbox"/> Chronic Coughing <input type="checkbox"/> Frequent Need to Clear Throat <input type="checkbox"/> Sore Throat, Hoarseness <input type="checkbox"/> Swollen or Discolored Tongue <input type="checkbox"/> Canker Sores
<b>Skin:</b> <input type="checkbox"/> Acne <input type="checkbox"/> Hives, Rashes, Dry Skin <input type="checkbox"/> Hair Loss <input type="checkbox"/> Flushing, Hot Flashes <input type="checkbox"/> Excessive Sweating	<b>Joints / Muscles:</b> <input type="checkbox"/> Pain or Aches in Joints <input type="checkbox"/> Arthritis <input type="checkbox"/> Stiffness or Limited Movement <input type="checkbox"/> Pain or Aches in Muscles <input type="checkbox"/> Weakness or Fatigued Muscles	<b>Other:</b> <input type="checkbox"/> Frequent Illness <input type="checkbox"/> Frequent or Urgent Urination <input type="checkbox"/> Genital Itch or Discharge
<b>GRAND TOTAL:</b>		