BIRMINGHAM CHIROPRACTIC CLINIC P.C.

DR. DAVID KIRSCH DR. JOEL KIRSCH

BCC 009

Patient Information

Date: _____

Full Name:_____ Nickname: _____

Address:_____

City:_____ State:_____ Zip:_____

Phone: *Home*:_____ *Work*:_____ *Cell*:_____

If necessary, may we contact you at the above #'s? (Please specify if there is a preferred time &/or # to reach you at)

[ ] Yes:_____

[ ] No

Email:_____

Social Security Number:_____

Date of Birth:_____/_____/_____

Occupation:_____

Employer:_____

Employer's Address:_____

Marital Status (please circle): *Married / Widowed / Single / Separated / Divorced*

Spouse's Name (if applicable):_____

Number of Children:_____

Name of Minor's Parent (if applicable):_____

Contact in Case of Emergency:

Name:_____ Relationship:_____

Phone: *Home*:_____ *Work*:_____ *Cell*:_____

Payment is expected at the time of the visit:

Name or Person Responsible for Payment:_____

Relationship to Patient (if different than yourself):_____

Are you Insured?

[ ] Yes (Insurance Company and Group #):_____

[ ] No

Is the Patient Covered by Additional Insurance?

[ ] Yes (Insurance Company and Group #):_____

Subscriber's Name:_____ Birthdate:_____

Relationship to Patient:_____

[ ] No

*The above information is confidential and an important part of our records, so please fill out completely.

See Other Side

1173 S. ADAMS RD. • BIRMINGHAM, MICHIGAN 48009
PHONE: (248) 644-9495 FAX: (248) 644-3151

BIRMINGHAM CHIROPRACTIC CLINIC P.C.

DR. DAVID KIRSCH DR. JOEL KIRSCH

Name: **Date:**

General

_____ Fever
_____ Chills
_____ Night Sweats
_____ Recent Infection
_____ Sleep Disturbance
_____ Weight Loss or Gain
_____ Cancer
_____ Tumors, Growths
_____ Anemia, Blood Disorders
_____ Diabetes
_____ Allergies
_____ Thyroid Disease
_____ AIDS/HIV
_____ Suicide Attempt
_____ Alcoholism
_____ Drug Abuse
_____ Chemical Dependency
_____ Eating Disorder
_____ Sexually Transmitted Disease
_____ Hepatitis
_____ Psychiatric Care
_____ High Stress Level

Musculoskeletal

_____ Neck Pain
_____ Upper Back Pain
_____ Low Back Pain
_____ Hip Pain
_____ Swollen Joints
_____ Painful Joints
_____ Dislocated Joints
_____ Muscle Aches/Soreness
_____ Scoliosis
_____ Arthritis
_____ Gout
_____ Osteoporosis
_____ Connective Tissue Disease
_____ Prosthesis

Women & Men

_____ Pregnant
_____ C-Section
_____ Irregular Cycles, Flow
Date of last Menses _____

_____ Painful Intercourse
_____ Testicular Problems
_____ Prostate Problems

Cardiovascular

_____ High Blood Pressure
_____ High Cholesterol
_____ Heart Disease
_____ Previous Heart Trouble, Heart Attacks
_____ Palpatations
_____ Ankle Swelling
_____ Varicose Veins
_____ Rheumatic Fever
_____ Scarlet Fever
_____ Stroke
_____ Pacemaker

Respiratory

_____ Difficult Breathing
_____ Chronic Cough
_____ Asthma
_____ Pneumonia
_____ Tuberculosis
_____ Emphysema
_____ Bronchitis
_____ Chest Pain

Eye Ear Nose Throat

_____ Poor Vision
_____ Deafness/Difficulty Hearing
_____ Sinus Trouble
_____ Dental Problems

Family History

_____ Diabetes
_____ Kidney Disease
_____ High Blood Pressure
_____ Heart Disease
_____ Cancer
_____ Muscle, Bone or Nerve Disease
_____ Arthritis

GU

_____ Frequent Urination
_____ Painful Urination
_____ Blood in Urine
_____ Kidney Disease, Stones
_____ Urinary Infection
_____ Stress Incontinence
_____ Inability to Control Urination

GI

_____ Poor Appetite
_____ Poor Digestion
_____ Difficulty Swallowing
_____ Frequent Nausea
_____ Vomiting
_____ Abdominal Pain
_____ Ulcer
_____ Loss of Bowel Control
_____ Liver Disease
_____ Gall Bladder Problems
_____ Hernia
_____ Diarrhea
_____ Constipation
_____ Hemorrhoids
_____ Appendicitis
_____ Colitis

Neurologic

_____ Weakness
_____ Seizures
_____ Tremors
_____ Headaches
_____ Fainting
_____ Dizziness
_____ Epilepsy
_____ Numbness/Tingling
_____ Arm Pain
_____ Leg Pain
_____ Mental Disorders
_____ Muscular Disorders
_____ Migraines
_____ Multiple Sclerosis
_____ Parkinson's Disease
_____ Polio

Lifestyle

_____ Recreational Drug Use
Smoking _____ Packs/Day
Alcoholic Beverages _____ Drinks /Week
Coffee _____ Cups/Day

How is your ***diet*** in general (please circle)?

Excellent / Good / Fair / Poor

How many times do you ***exercise*** in a week (please circle)?

None / 1-2 / 3-5 / 6-7

Work Activity

_____ Retired
_____ Not Employed
_____ Sedentary
_____ Light Duty (Lift < 20lbs)
_____ Medium Duty (Lift < 50lbs)
_____ Heavy Duty (Lift < 100lbs)
_____ Very Heavy Duty (Lift > 100lbs)

Medications & Nutritional Status

Medications & Vitamins (please list)_____

Hopitalizations, Surgeries & Accidents

List Dates & Type of Injury _____

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