NEW PATIENT MEDICAL FORM

Name:_____ Date of scheduled appointment: _____

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____

Email: _____ Skype ID:_____

Date of Birth:_____Gender:_____Height:_____Weight:_____

Social Security Number:_____

Name of Your Employer:_____

Type of Work:_____

Circle if you are: Single Married Widowed Divorced Separated

Name and telephone number of person to contact in case of emergency:_____

_____

Name of husband or wife:_____

Husband or wife's employer:_____

Referred to this office by: _____

LIST YOUR MAJOR PRESENT HEALTH COMPLAINT (IN ONE SENTENCE):_____

_____

DURATION OF PRESENT CONDITION (HOW LONG):_____

Have you been treated before for this problem? ☐ No ☐ Yes

If yes, by ☐ Physician ☐ Chiropractor ☐ Physical Therapist ☐ Osteopath

☐ Other:_____

What did they do and/or recommend?_____

What was their diagnosis?_____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

CIRCLE ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST:

Alcoholism
Anemia
Appendicitis
Arthritis
Breast Lumps
Cancer
Chicken Pox
Diabetes
Diphtheria
Eczema
Epilepsy
Goiter
Gout
Heart Disease
Hepatitis
High Cholesterol
Hernia
Influenza
Kidney Disease
Liver Disease
Lumbago
Malaria
Measles
Mental Disorders
Migraine Headaches
Multiple Sclerosis
Mumps
Pacemaker
Pleurisy
Polio
Pneumonia
Rheumatic Fever
Scarlet Fever
Stroke
Smallpox
Tuberculosis
Typhoid Fever
Ulcers
Venereal Infection
Whooping Cough
Other:_____

Please underline all of the following symptoms you have had PREVIOUSLY.
Please circle all of the symptoms you have NOW.

GENERAL SYMPTOMS
Headache
Fever
Chills
Sweats
Fainting
Dizziness
Convulsions
Numbness / pain in arms, hands, or legs
Allergy
Wheezing
Weight gain
Loss of weight
Loss of sleep
Bruises easily
Neuralgia

E.E.N.T.
Failing vision
Nearsightedness
Farsightedness
Crossed eyes
Eye pain
Deafness
Earache
Ear noises
Ear discharge
Nosebleeds
Nasal obstruction
Sore throat
Hoarseness
Asthma
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sinus infection
Nasal drainage
Enlarged glands
Hay fever

SKIN
Skin Eruptions
Itching
Dryness
Boils
Varicose veins
Sensitive skin
Hives or allergy
Sores that wouldn't heal

RESPIRATORY
Chronic cough
Spitting-up phlegm
Spitting-up blood
Chest pain
Difficulty breathing

CARDIOVASCULAR
Rapid heartbeat
Slow heartbeat
High blood pressure
Low blood pressure
Pain over heart
Previous heart stroke
Hardening of arteries
Swelling of ankles
Poor circulation
Paralytic stroke
Chest pain

GENITOURINARY SYMPTOMS
Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection of stones
Bed wetting
Inability to control urine
Prostate trouble

GATROINTESTINAL
Poor appetite
Difficult digestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Vomiting of blood
Pain over stomach
Distention of abdomen
Constipation
Diarrhea
Colon trouble
Hemorrhoids (piles)
Intestinal worms
Liver trouble
Gall bladder trouble
Jaundice
Colitis

FOR MEN ONLY
Breast lumps
Erection difficulties
Lump in testicle
Penis discharge
Sore on penis
☐ Other:_____

FOR WOMEN ONLY
Are you pregnant?___
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Previous miscarriage
Vaginal discharge
Lumps in breast
Menopausal symptoms
Painful menstrual periods
☐ Other:_____

NECK, BACK, EXTREMITIES: Please underline all of the following symptoms you had previously. Please circle all of the symptoms you have NOW.

NECK
Pain in neck
Neck stiffness
Neck weakness
Pinched nerve in neck
Neck feels out of place
Muscle spasms in neck
Grinding/popping sounds in neck

SHOULDERS
Pain in shoulder joint ☐ Right ☐ Left
Pain across shoulders
Can't raise arm ☐ Right ☐ Left
☐ Above shoulder level
☐ Over head
Tension in shoulders
Pinched nerve in shoulder ☐ Right ☐ Left

MID-BACK
Mid-back pain
Mid-back stiffness
Pain between shoulder blades
Pain from front to back
Muscle spasms in mid-back

LOW BACK
Low back pain
Low back stiffness
Low back weakness
Pinched nerve in low back
Low back feels out of place
Muscle spasms in low back

ARMS & HANDS
Pain in upper arm ☐ Right ☐ Left
Pain in elbow ☐ Right ☐ Left
Pain in forearm ☐ Right ☐ Left
Pain in hand ☐ Right ☐ Left
Pain in fingers ☐ Right ☐ Left
Pins & needles in fingers ☐ Right ☐ Left
Numbness in arm ☐ Right ☐ Left
Numbness in fingers ☐ Right ☐ Left
Weakness of arm ☐ Right ☐ Left
Weakness of hand ☐ Right ☐ Left
Hands cold ☐ Right ☐ Left

HIPS, LEGS & FEET
Pain in buttocks ☐ Right ☐ Left
Pain in hip joint ☐ Right ☐ Left
Pain down leg ☐ Right ☐ Left
Pain in ankle ☐ Right ☐ Left
Pain in foot ☐ Right ☐ Left
Weakness of leg ☐ Right ☐ Left
Weakness of knee ☐ Right ☐ Left
Leg cramps ☐ Right ☐ Left

OTHER SYMPTOMS
_____
_____
_____
_____
_____
_____

PAST HEALTH HISTORY

OPERATIONS/SURGERIES AND YEARS PERFORMED: _____

Organs/Glands removed: _____

VACCINATIONS AND INJECTIONS RECEIVED:

☐ Diphtheria ☐ Polio ☐ Tetanus ☐ Spinal tap or injections ☐ Typhoid ☐ Smallpox
☐ Other: _____

HABITS: ☐ Coffee ☐ Tea ☐ Alcohol ☐ Tobacco
☐ Exercise ☐ Hobbies ☐ Sleep (Hours): _____

ACCIDENTS OR FALLS (Please Describe): _____

Fractures or dislocations:_____

_____

Drugs (medications) you are currently taking:_____

_____

Allergies: _____

Have you ever had a nervous breakdown?_____

Have you ever been treated for any mental disorders?_____

Has any member of your family been treated for a mental disorder?_____

FAMILY HEALTH HISTORY

RELATION NAME AGE SIGNIFICANT ILLNESSES

Father:_____
Mother:_____
Brother:_____
Brother:_____
Sister:_____
Sister:_____
Child:_____
Child:_____
Child:_____

ANY ADDITIONAL INFORMATION YOU FEEL WE SHOULD KNOW, PLEASE ADD HERE:

_____
_____
_____
_____

FINANCIAL RESPONSIBILITY

Who is responsible for your bill: ☐ Self ☐ Insurance ☐ Employer (Worker's Comp.)
☐ Automobile Insurance ☐ Other:_____

Policy holder's name (if different from yourself):_____

Policy holder's date of birth:_____

Any charges not covered by insurance are the responsibility of the patient. The patient is responsible for meeting the payment requirements of the insurance policy regarding deductibles and co-payments, and also payment for services not covered by the insurance policy.

_____ _____
Patient's Signature Date of Signature

IF PATIENT IS A MINOR, PARENT OR LEGAL GUARDIAN MUST SIGN FORM

Diverse Health Services PLLC
R.E. Tent D.C., N.D., Ph.D.
Jeff Senechal B.A., D.C.
24230 Karim Blvd, Suite 130
Novi, MI 48375
(248) 477-0380

It has been explained to me, and I understand that R.E. Tent D.C. & Jeff Senechal D.C. are Chiropractors, and not medical or osteopathic physicians. As a result, this practice and the care provided is limited to that which is permitted by State Law. We do not provide the type of care or treat conditions that fall within the scope of practice of Medical Doctors, and do not treat or offer cures for diseases or illnesses such as cancer, diabetes, or other similar conditions.

R.E. Tent D.C. and Jeff Senechal D.C. may provide nutritional advice or support. I understand that this advice and support is provided for general health and is not offered as treatment for a disease or illness. Medical doctors or specialists must treat any disease or illness that I may have.

I have read this statement, I have had the opportunity to discuss it with the staff, and agree with it. I acknowledge that R.E. Tent D.C. and Jeff Senechal D.C. are not treating me for any disease or illness and agree not to hold them responsible for any such condition.

With this knowledge, I freely and willingly consent to the recommended course of treatment.

Signed:_____ Date:_____

Staff:_____ Date:_____

DIVERSE HEALTH SERVICES, PLLC
24230 KARIM BLVD, SUITE 130, NOVI MI 48375
PHONE(248) 477-0380 FAX (248)477-8320

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and accreditation.

_____

{Please Print Name}

_____

{Signature}

_____

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)_____

Staff Signature Date