Petchauer Chiropractic LLC

Welcome!

Date_____

12978 James St. Ste 10, Holland MI. 49424
616-394-0112

Name_____Address_____

City_____ State_____Zip Code_____ Age_____

Phone Numbers: Home_____ Work_____ Cell_____

Email: _____ (To receive weekly newsletter)

Date of Birth_____ Male or Female Marital Status: M S W

Number of Children_____Ages:_____ Female: Are you Pregnant ? Yes No Uncertain

Occupation_____Employer_____

How were you referred to our office? _____

Purpose of this appointment:_____ Due to Injury (work or auto)?_____

Have you had a physical examination in the last year? Yes No

Please list all medications that you currently take:

1. _____ Reason:_____
2. _____ Reason:_____
3. _____ Reason:_____
4. _____ Reason:_____
5. _____ Reason:_____

Please list all surgeries that you have had:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any medically diagnosed conditions that you have:
(examples: high blood pressure, diabetes, etc.)

_____

_____

Are there any other health problems that you would like to discuss?

_____

_____

Is there something in your life that you feel passionate about?

_____

- Please complete other side -

Please check all of the following that you are now experiencing or have recently experienced.

General	**Muscle & Joint**	**Gastrointestinal**
❑ Headache	❑ Arthritis	❑ Colon problems
❑ Dizziness	❑ Neck pain / stiffness	❑ Constipation
❑ Fever	❑ Mid back pain	❑ Diarrhea
❑ Fatigue	❑ Low back pain	❑ Difficult digestion
❑ Loss of sleep	❑ Sciatica	❑ Heartburn / Reflux
❑ Weight loss	❑ Spinal curvature	❑ Gallbladder problems
❑ Memory loss	❑ Bad posture	❑ Liver problems
❑ Nervousness	❑ Muscle spasms	❑ Nausea
❑ Allergies		❑ Stomach pain
	Problems with	❑ Hemorrhoids
Skin	❑ TMJ (jaw)	
❑ Acne	❑ Shoulders	**Cardio-Vascular**
❑ Bruise easily	❑ Arms	❑ Hardening of arteries
❑ Dryness	❑ Elbows	❑ High blood pressure
❑ Psoriasis	❑ Hands/Wrists	❑ Low blood pressure
❑ Eczema	❑ Hips	❑ Pain over heart
❑ Itching	❑ Legs	❑ Poor circulation
	❑ Knees	❑ Rapid heart beat
Respiratory	❑ Feet/ankles	❑ Slow heart beat
❑ Asthma		❑ Swelling of ankles
❑ Chest pain	**Genito-urinary**	
❑ Chronic cough	❑ Frequent urination	**Eyes, Ears, Nose & Throat**
❑ Difficult breathing	❑ Painful urination	❑ Colds/Sore throat
❑ Spitting up phlegm	❑ Bed-wetting	❑ Deafness/Hearing loss
❑ Wheezing	❑ Kidney infection	❑ Earache
	❑ Kidney stones	❑ Ear infection
For Women only	❑ Prostate trouble	❑ Ear noises
❑ Irregular cycle	❑ Urinary tract infection	❑ Eye pain
❑ Hot flashes		❑ Loss of taste
❑ Painful menstruation		❑ Loss of speech
❑ Excessive menstrual flow		❑ Ringing in ears
❑ Menopausal symptoms		❑ Sinus infection
❑ Lumps in breast		❑ Vision changes

I acknowledge all my responses are accurate to the best of my knowledge. I give my permission for Dr. Petchauer and his staff to examine and treat me as warranted by my condition.

Signature _____ Date _____

(Patient under 18, parent or guardian signature required)

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