 ***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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