 ***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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