Positively
CHIROPRACTIC
PREGNANCY, FAMILY, PEDIATRIC

Welcome to **Positively Chiropractic.** Our mission is to restore and maximize health for all families and individuals in our community. Please take a few moments to completely fill out this form. We will take GREAT care of you here!

New Practice Member Information

Name: ______________________________ Date: ____________________

Address: ______________________________ City: ______________ State: _______ Zip: ___________

Phone: ____________________ Cell: ____________________ Email: ______________________________

Date of Birth: __________ Current Age: __________ Gender or Preference: ______________________________

Marital Status: _______________ Spouse/Partner's Name: ______________________________

Are you Pregnant? _____ Number of Children: ____ Children's Names/Ages: ______________________________

Occupation: ______________________________ Current Employment: ______________________________

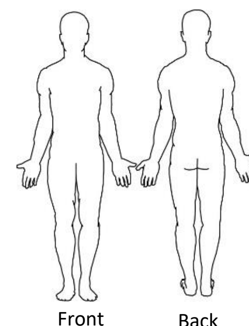
How did you hear about our office? ______________________________

Emergency Contact: ______________________________ Relationship: ___________Phone #: ________________

Reason for Seeking Care

*Please briefly describe the area of chief complaint(s). Intensity scale: 0=None 10=unbearable. Circle areas of irritation on the image below. *If you have no complaints, and are seeking chiropractic care for wellness, indicate "none" below.*

Area	Duration	Pain Scale
1. ________________________	__________________	0 1 2 3 4 5 6 7 8 9 10
2. ________________________	__________________	0 1 2 3 4 5 6 7 8 9 10
3. ________________________	__________________	0 1 2 3 4 5 6 7 8 9 10



Based on your complaint

How did your complaint begin? Was there an injury? ______________________________
____

What is the character of your pain/symptoms (sharp, achy, dull, etc.)? ______________________________
____

What makes it worse? ____________________________ What makes it better? __________________________

Do your symptoms stay in the same place or do they radiate/travel? Describe: ______________________________
____

Circle how often is it present? *Intermittent* (<50%) *Frequent* (51-75%) *Constant* (>75%)

Since your problem began, is it: *Getting better* *Staying the Same* *Getting Worse*

Who else have you seen for this? *None* *Chiropractor* *MD* *Other* If so, who/when? ____________________

Please describe how your health concerns are affecting your life: ______________________________

The Power that Made the Body, Heals the Body

______________________________ ______________________________
Dr. Erin Clifton Dr. Sarah Prater-Manor

Positively Chiropractic 134 E. Main, PO Box 360 Stockbridge, Mi 49285 517-851-3850

Body Signals of Current and Past Underlying Dysfunction

Please indicate which of the following body signals you have experienced or are currently experiencing.

- ☐ Acid Reflux/Heartburn
- ☐ Allergies/Sinus Issues
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bed Wetting
- ☐ Blurred Vision
- ☐ Cancer
- ☐ Cardiac Conditions
- ☐ Cold Feet/Hands
- ☐ Constipation
- ☐ Depression
- ☐ Diabetes
- ☐ Disc Problems
- ☐ Dizziness
- ☐ Ear Infections
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fatigue
- ☐ Gall Bladder Trouble
- ☐ Headaches/Migraines
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Hip Pain
- ☐ Irritable Bowel
- ☐ Indigestion
- ☐ Jaw Pain/TMJ
- ☐ Kidney Condition/Disease
- ☐ Liver Disease
- ☐ Loss of Balance
- ☐ Loss of Smell
- ☐ Low-back Pain
- ☐ Lupus
- ☐ Memory Loss
- ☐ Menstrual Irregularity
- ☐ Mid-back Pain
- ☐ Nausea
- ☐ Neck Pain
- ☐ Nervousness
- ☐ Numbness in Arms/Hands
- ☐ Numbness in Leg/Feet
- ☐ Pain in Legs/Feet
- ☐ Pins/Needles Arms/Hands
- ☐ Pins/Needles Legs/Feet
- ☐ Prostate Trouble
- ☐ Ringing in Ears
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Shoulder/Arm Pain
- ☐ Stiffness
- ☐ Stomach Condition
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Ulcers
- ☐ Vertigo
- ☐ Other

Physical, Chemical, Emotional Stressors

Stress that occurs in our lifetime impacts our health. To better take care of you, it is important for us to understand the physical, chemical, and emotional stresses you have endured over time.

Physical *(Circle One)*

Did your birth include the following? *Cesarean* *Vaginal* *Unknown* *Vacuum/forceps*

Which is your typical work week? *Sitting* *Standing* *Walking* *Lifting*

Have you experienced the following? *Falls* *Surgeries* *Fractures* *Injuries* *Hospitalizations*

Describe your sleep patterns. *Side* *Back* *Stomach* Duration: *<4 Hours* *5-8 Hours* *8+ Hours*

Have you been in any auto accidents? *Yes* *No* Date of Accident: _____________ Injuries: ________________

Describe the accident: ____

Chemical *(Circle One)*

Have you been vaccinated as a child or adult? *Yes/No* Last One Received? ________ Bad Reactions?_____________

Do you: *Smoke Tabacco* *Use Recreational Drugs* *Drink Alcohol*

Do you consume: *Fried Foods* *Soda/Pop* *Dairy* *Caffeine* *Sweeteners*

Please list supplements/dosages you take on a regular basis: ____

____

____

____

Emotional *(Circle One)*

Do you consider yourself: *Overstressed* *Lonely* *Anxious* *Depressed*

Have you experienced: *Loss of a Loved One* *Divorce* *Loss of a Job* If so, when? ______________

What steps are you taking to heal and connect from this? ____

Rate your job satisfaction: (low) 0 1 2 3 4 5 6 7 8 9 10 (high)

Rate your personal fulfillment: (low) 0 1 2 3 4 5 6 7 8 9 10 (high)

Health History

Please list all medications you are taking (if more than 4, please attach a list to this paperwork):

Medication: ________________________________ Reason: __________________________ Dosage: _________
Medication: ________________________________ Reason: __________________________ Dosage: _________
Medication: ________________________________ Reason: __________________________ Dosage: _________
Medication: ________________________________ Reason: __________________________ Dosage: _________

Please list any broken bones, surgeries, or hospitalizations you have had:

Incident: ____ Date: ________________
Incident: ____ Date: ________________
Incident: ____ Date: ________________

Please list any auto accidents you have been in:

Incident: ____ Date: ________________
Incident: ____ Date: ________________
Incident: ____ Date: ________________

Positive Lifestyle Habits

Please answer the questions below by describing or marking the answers that apply to your current lifestyle.

Physical:

Cardiovascular Exercise   Strength Training   Swimming   Biking   Yoga/Pilates   Other:______________________

How often do you exercise each week? _______________

Chemical:

Organic Foods   Vitamins/Supplements   Use of non-chemical cleaners   Other: ______________________________

How many glasses of pure water do you drink per day? __________

On average, how many servings of vegetables do you eat per day? ___________

Emotional:

Spiritual Meditation   Counseling   Support Groups   Other:____

Have you ever been to a chiropractor before? Yes/No

How important is finding the cause of your health concerns? (low) 1 2 3 4 5 6 7 8 9 10 (high)

How important is the quality of your life? (low) 1 2 3 4 5 6 7 8 9 10 (high)

What are your goals for chiropractic care? Remove Pain   Restore Health   Full Health Potential

Why do you have this goal? ____

Other Health Goals: ____

Other Care Providers

Our office seeks to provide the best care for you. We do that by connecting with your other providers to find solutions for your health. Please fill out the information below for providers that you currently see on a regular basis.

MD or Family Physician: _________________________ Location: ____
Dentist: ______________________________________ Location: ____
Physical Therapist: ______________________________ Location: ____
Massage Therapist: _____________________________ Location: ____

Do we have permission to contact any of the above mentioned providers? If so, please sign and date below:

Signature: _______________________________   **Date:** ____________________________

Please Continue to Back

Consent to Care

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to a health professional we believe will help you. In order for us to understand your health problems properly, please ensure the form is neat, accurate and complete.

I AUTHORIZE DR. ERIN CLIFTON, DR. SARAH PRATER-MANOR, AND ALL POSITIVELY CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS FOR MYSELF.

Signature: ____ **Date:** __________________________

Consent to Care for a Minor

If this health intake form is for a minor/child, please fill out and sign below.
Name of patient who is a minor/child: _______________________________ Date of birth of minor: ____________
I AUTHORIZE DR. ERIN CLIFTON, DR. SARAH PRATER-MANOR, AND ALL POSITIVELY CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY POSITIVELY CHIROPRACTIC.

Guardian Signature: ___________________________ **Date:** __________ **Relationship to minor:** ________________
Witness Signature (Staff): ________________________ Date: __________

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.
- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for care or by mail. Please feel free to call us at any time for a copy of our privacy notices.
Your right to limit uses or disclosure: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.
Your right to authorization: You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revote authorization. If you were required to file your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.
***I have read this consent policy and agree to its terms. I am also acknowledging that I have received a copy of this form.**

Printed Name: ______________________________ Signature: ___________________________ Date: ______________
Authorized Provider Representation: _________________________________ Date: ______________________

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____ ____
Dr. Erin Clifton Dr. Sarah Prater-Manor