VAN BORN CHIROPRACTIC CLINIC P.C • 23610 VAN BORN RD, DEARBORN HGTS., MI 48125
RENEE I. PETHTEL, DC • DONALD G. PETHTEL, DC • (313) 291-1060

PATIENT INTRODUCTION CARD

Date: __________ Email: ____________________ Patient # __________
Patient Name: Last ____________________ First ____________________ Init. ______
Address: ____________________ City ____________________ State ______ Zip __________
Phone: ( ) ______ - __________ Birthdate: ____/____/____ Age ______
Sex: (M-male, F-female): ______ Marital Status: M S W D Patient Soc. Sec. #: __________
Patient Employed By: ____________________
Occupation: ____________________ Business Phone: ( ) ______ - ______
Insurance Coverage: ____________________ Spouses Birthdate: ____/____/____
Referred By: ____________________
Briefly Describe Chief Complaint (Symptoms) ____________________
____
How did it happen? ____________________
How would you rate your pain today (0 being no pain and 10 being the worst pain) __________
What have you done to try to help this problem so far? ____________________
Have you ever had same or similar complaint? Yes or No Explain ____________________
List all other health problems and symptoms you are having: ____________________
____
List all past surgeries ____________________
List all medications you are currently taking __________ for __________ __________ for __________
__________ for __________ __________ for __________ __________ for __________
Have you been to a chiropractor before? Yes or No If Yes, for what? ____________________
FEMALES ONLY: To your knowledge are you pregnant? Yes or No (Circle One)
Are You Claiming Workmen's Compensation: YES __________ NO __________
Are You Claiming Auto Accident: YES __________ NO __________
Company or Insurance Name: ____________________
Address: ____________________ Phone #: ( ) - __________

Patient Signature ____________________ Date: __________

- ☐ I Am Interested in Only Symptomatic Relief (Feel Better)
- ☐ I Am Interested in Symptomatic Relief, and Maximum Correction of My Problem
- ☐ I Am Interested in Symptomatic Relief, Maximum Correction and a Health Maintenance Plan

Do You Have Any Problems With The Following ☒ PRESENT ☐ PAST

☐ Low blood pressure	☐ Ringing in ears	☐ Shortness of breath	☐ Bladder trouble
☐ High blood pressure	☐ Hay fever	☐ T.B.	☐ Menstrual cramps, pain
☐ Arterio sclerosis	☐ Asthma	☐ Chest pain	☐ Menstrual irregularity
☐ Cardiovascular disease	☐ Allergies	☐ Heart palpatations	☐ Cancer
☐ Diabetes	☐ Tightness of throat	☐ Heart attacks	☐ Sleeping problems
☐ Cervical arthritis	☐ Thyroid trouble	☐ Chest and left arm pain	☐ Painful joints
☐ Recent severe neck strain	☐ Face flushed	☐ Anemia	☐ Swollen joints
☐ Family history of strokes	☐ Twitching of face	☐ Rheumatic Fever	☐ Arthritis
☐ Dizziness or unsteadiness	☐ Fatigue	☐ Nervous stomach	☐ Slipped disc
☐ Fainting or lightheadedness	☐ Depression	☐ Ulcers	☐ Ruptured disc
☐ Temporary loss of memory	☐ Head feels too heavy	☐ Mid back pain	☐ Previous disc surgery
☐ Numbness in face or arms	☐ Muscle spasms in neck	☐ Nerves, nervousness	☐ Low back pain
☐ Garbled speech	☐ Increased pain to cough, sneeze	☐ Inner tension	☐ Pinched nerves in back
☐ Vision problems	☐ Grating in neck	☐ Irritability	☐ Leg pain
☐ Recent severe, sudden head pain	☐ Neck pain	☐ Liver trouble	☐ Numbness in legs
☐ Chronic headaches	☐ Tightness of shoulder muscles	☐ Gall bladder trouble	☐ Swollen ankles
☐ Migraine headaches	☐ Pins and needles in arms, hands	☐ Indigestion	☐ Cold feet
☐ Sinus trouble	☐ Cold hands	☐ Intestinal gas	☐ Pains in legs & feet
☐ Loss of balance	☐ Bursitis	☐ Constipation	
☐ Loss of smell	☐ Cold sweats	☐ Kidney trouble	

ANY FALLS, ACCIDENTS, INJURIES? ☐ YES ☐ NO
If yes, please explain ____________________
____

Please specify the Doctor of your choice: ____________________
PLEASE RETURN THIS FORM WITH YOUR INSURANCE CARD TO FRONT DESK

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COMPREHENSIVE HEALTH QUESTIONNAIRE

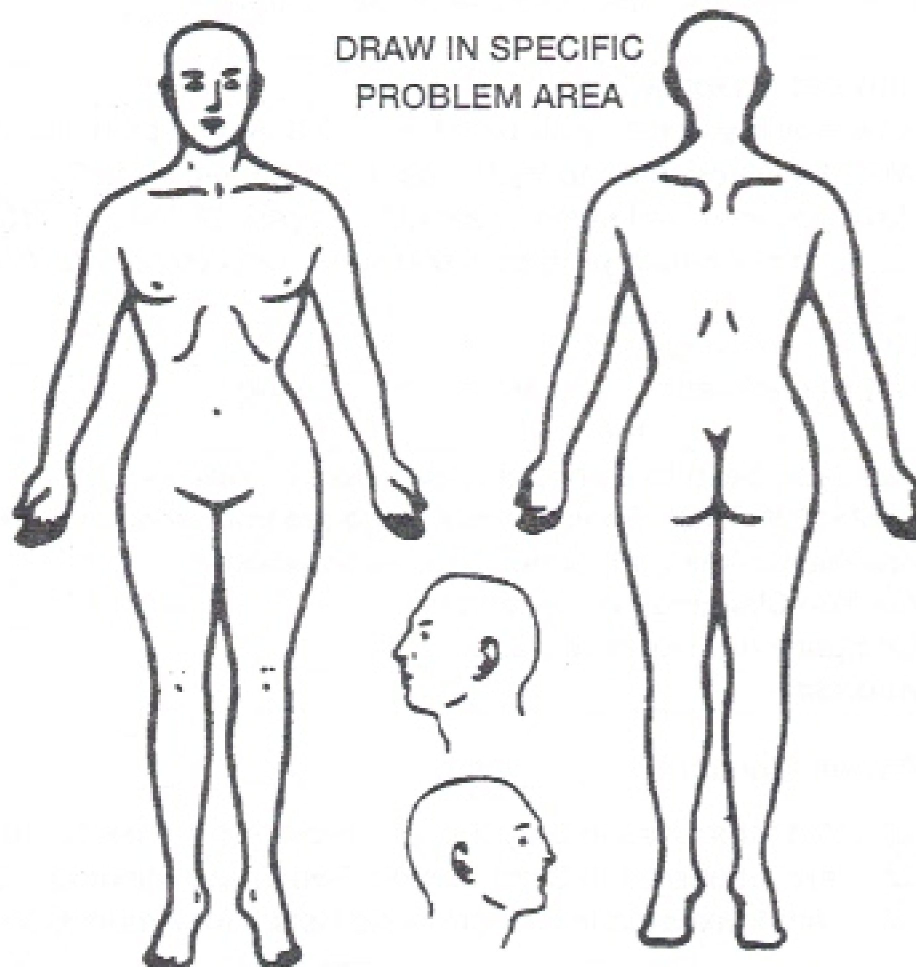
INSTRUCTIONS: PLEASE ANSWER THE FOLLOWING QUESTIONS, YES, IF YOU HAVE OR HAVE HAD PROBLEMS
NO, IF YOU HAVE NEVER HAD A PROBLEM.

PATIENT NAME: ____________________

DO YOU EXERCISE REGULARLY? YES___ NO___
DO YOU SUFFER FROM SEVERE HEADACHES? YES___ NO___
DO YOU HAVE CONVULSIONS OR EPILEPSY? YES___ NO___
PARTS OF YOUR BODY EVER PARALYZED? YES___ NO___
WERE YOU EVER KNOCKED UNCONSCIOUS? YES___ NO___
DO YOU HAVE DIFFICULTY SLEEPING? YES___ NO___
DO YOU SMOKE OR DRINK EXCESSIVELY? YES___ NO___
DO YOU DRINK A LOT OF COFFEE? YES___ NO___
DO YOU HAVE SPELLS OF EXHAUSTION? YES___ NO___
DO YOU GET UP TIRED IN THE MORNING? YES___ NO___
ARE YOU FREQUENTLY ILL? YES___ NO___
HAVE YOU HAD ANY OF THE FOLLOWING WITHIN THE LAST YEAR?
A. COMPLETE PHYSICAL EXAMINATION YES___ NO___
B. HEART EXAMINATION YES___ NO___
C. BLOOD PRESSURE CHECK YES___ NO___
D. MEDICAL CARE YES___ NO___
E. CHIROPRACTIC CARE YES___ NO___
DOES ARTHRITIS RUN IN YOUR FAMILY? YES___ NO___
DO YOU GET UP AT NIGHT AND URINATE? YES___ NO___
DO YOU BLACK OUT OR FAINT? YES___ NO___
IS THERE CONSTANT NOISE IN EARS? YES___ NO___
DO YOU HAVE SINUS PROBLEMS? YES___ NO___
DO YOU HAVE ALLERGYS? YES___ NO___
DO YOU COUGH UP BLOOD? YES___ NO___
DO YOU HAVE NIGHT SWEATS? YES___ NO___
PAINS IN THE HEART OR CHEST? YES___ NO___
DIFFICULTY IN BREATHING? YES___ NO___
OUT OF BREATH BEFORE ANYONE ELSE? YES___ NO___
ANKLES BADLY SWOLLEN? YES___ NO___
SUFFER FROM CRAMPS ON YOUR LEGS? YES___ NO___
DO YOU HAVE HEART TROUBLE? YES___ NO___
DO YOU HAVE BADLY COATED TONGUE? YES___ NO___
DO YOU EAT SWEETS BETWEEN MEALS? YES___ NO___
SUFFER FROM INDIGESTION? YES___ NO___
DOUBLE UP FROM SEVERE STOMACH PAINS? YES___ NO___
LOOSE BOWEL MOVEMENTS? YES___ NO___
BAD CONSTIPATION? YES___ NO___
PAINFUL MENSTRUAL PERIODS? YES___ NO___
SEVERE HOT FLASHES AND SWEATS? YES___ NO___
RECENT AND RAPID WEIGHT LOSS? YES___ NO___

HEIGHT ____________ WEIGHT ____________

(Circle One)
ACTIVITY LEVEL: Sedentary - Active - Very Active
STRESS LEVEL: Minimal - Moderate - Great



P PAIN-CONSTANT OR FREQUENT (MAIN PROBLEM)
C PAIN-OFF & ON, INFREQUENT OR CHRONIC
N NUMBNESS, TINGLING, OR BURNING

ADDITIONAL COMMENTS ____________________

FAMILY HEALTH HISTORY RECORD

NAME & ADDRESS	DATE OF BIRTH	HEALTH HISTORY PREVIOUS YEARS	PRESENT
HUSBAND OR WIFE:			
CHILDREN:			
MOTHER:			
FATHER:			
SISTERS: BROTHERS:			

IN CASE OF EMERGENCY, WHO CAN WE CALL OTHER THAN YOUR HOME?

NAME ADDRESS RELATIONSHIP HOME PH. WORK H.

CURRENT MEDICAL DOCTOR? ____________________ PHONE # ____________________

WHICH HOSPITAL WOULD YOU PREFER IN CASE OF AN EMERGENCY? ____________________

Patient Signature ____________________ Date: ____________