Penn Chiropractic Centre

1905 Horton Road
Jackson, MI 49203
(517) 784-7443
www.docpenn.com

WELCOME TO OUR OFFICE

Patients Full Legal Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Social Security# _____ Referred by _____

Employer _____ Occupation_____

Best Contact Number Cell _____ Home _____ Work_____

Email _____

Marital Status S M D W Spouses Name_____

Spouses Occupation _____ Number of Children & Ages_____

Have you ever received Chiropractic Care? ☐ Yes ☐ No

IF UNDER 18 YEARS OF AGE

Responsible Party _____

Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Insurance #1

Policy Holders Name _____ Policy Holders Address _____

DOB _____ City _____ State _____ Zip _____

Relationship to you _____

Employer _____

Insurance #2

Policy Holders Name _____ Policy Holders Address _____

DOB _____ City _____ State _____ Zip _____

Relationship to you _____

Employer _____

My Financial Responsibility

I certify that the above information is correct. I understand that I am personally, financially responsible for all services not paid for by my insurance. I am responsible for any annual deductibles, co Payments, or non-covered services as may be required by my insurance plan.

My Authorization

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

_____ _____

Patient Signature or Responsible Party Date

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CASE HISTORY

Name_____ Date_____

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your Chiropractor will outline a course of care to correct these layers of damage and recover your innate health potential.

Loss of Wellness

Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

Yes	No	1. Birth Process	Patient Comment if answer is Yes	Chiropractor's Comment
☐	☐	Was the delivery Long?	_____	_____
☐	☐	Was the delivery difficult?	_____	_____
☐	☐	Forceps?	_____	_____
☐	☐	Caesarean?	_____	_____
☐	☐	Breach/Cephalic?	_____	_____
☐	☐	Home Birth?	_____	_____
☐	☐	Hospital Birth?	_____	_____
☐	☐	Mother given drug during Delivery?	_____	_____
☐	☐	Was labor induced?	_____	_____
		2. Growth and Development		
☐	☐	Were you taught how to care for your spine?	_____	_____
☐	☐	Did you fall out of bed?	_____	_____
☐	☐	Were you a head banger/rocker?	_____	_____
☐	☐	Were you breast fed?	_____	_____
☐	☐	Childhood sickness?	_____	_____
☐	☐	Accidents?	_____	_____
☐	☐	Surgery?	_____	_____
☐	☐	Drugs?	_____	_____
☐	☐	Did you fall while learning to walk?	_____	_____
☐	☐	Were you picked on by siblings?	_____	_____
☐	☐	Child abuse?	_____	_____
☐	☐	Spanked(how?)	_____	_____
☐	☐	Pulled ear/chin?	_____	_____
☐	☐	Other	_____	_____
☐	☐	Chair pulled out when you sat down?	_____	_____
☐	☐	Did you fall down stairs?	_____	_____
☐	☐	Were you yanked by your arm?	_____	_____
☐	☐	Did you have other traumas? What? When?	_____	_____
		3. Current Health Habits		
☐	☐	Did/do you smoke?	_____	_____
☐	☐	Did/do you drink alcohol?	_____	_____
☐	☐	Diet?	_____	_____
☐	☐	Have you been in accidents?	_____	_____
☐	☐	Have you had surgery and organs removed/replaced?	_____	_____
☐	☐	Drugs (prescriptive or non-prescriptive)?	_____	_____
☐	☐	Teething Problems?	_____	_____
☐	☐	Eye Problems?	_____	_____
☐	☐	Hearing Problems?	_____	_____
☐	☐	Exercise Regularly?	_____	_____
☐	☐	Sleeping Habits (nightmare?)	_____	_____
☐	☐	Did/do you have occupational stress?	_____	_____
☐	☐	Physical stress?	_____	_____
☐	☐	Mental Stress?	_____	_____
☐	☐	Hobbies/Sport Injuries?	_____	_____
☐	☐	Sleeping Posture ☐ side ☐ stomach ☐ back	_____	_____

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CASE HISTORY (Continued)

Name_____ Date_____

Symptoms and Ill Health (Present State of Ill Health)

Finally, the years of continuing damage showed up as acute or chronic symptoms.

Present Complaint (be brief) _____

Major _____

Pain or Problem started on _____

Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day?_____

Is this condition interfering with work?_____

Is this condition getting progressively worse?_____

Other doctors seen for this condition? _____

Any home remedies?_____

Other Symptoms:

☐ Headache	☐ Pins & Needles in Legs	☐ Fainting
☐ Neck Pain	☐ Pins & Needles in Arms	☐ Loss of Smell
☐ Sleeping Problems	☐ Numbness in Fingers	☐ Loss of Taste
☐ Back Pain	☐ Numbness in Toes	☐ Diarrhea
☐ Nervousness	☐ Shortness of Breath	☐ Cold Feet
☐ Tension	☐ Fatigue	☐ Cold Hands
☐ Irritability	☐ Depression	☐ Upset Stomach
☐ Chest Pains	☐ Light Bothers Eyes	☐ Constipation
☐ Dizziness	☐ Loss of Memory	☐ Cold Sweats
☐ Face Flushed	☐ Ears Ring	☐ Loss of Balance
☐ Neck Stiff	☐ Fever	☐ Buzzing in Ears

Have you been under drug and medical care? _____

What medications are you taking? _____

How Long? _____ Have you had surgery? _____ What? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's Side	☐	☐	☐	☐	☐
Mother's Side	☐	☐	☐	☐	☐

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layer of the Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then, begins **Reconstructive Care,** which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to **Wellness Care.** All of these options will be explained at your report of findings. Then you will be able to begin a course of care that fits your health goals.

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

> Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction is of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal, physical, mental, and social well-being, not merely the absences of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for these findings, we will recommend that you see the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer it to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. The Power That Makes The Body Can Heal The Body.

Minor Release:
I, _____ Being the parent or legal guardian of_____ have read and fully understand the above Terms of Acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:
This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his associates have my permission to perform and x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

I, _____ have read and fully understand the above statements.

_____ _____
Name of Patient or Responsible Party Date

_____
Patient Signature or Responsible Party

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Consent for Purpose of Treatment, Payment, and HealthCare Operations

I acknowledge that Dr. Randolph J. Penn's "Notice of Privacy Practices" has been provided to me.

I understand I have the right to review Dr. Randolph J. Penn's "Notice of Privacy Practices" prior to signing this document. The Notice of Privacy Practices describes the types pf uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operation of Randolph J. Penn, D.C. The Notice of Privacy Practices for Randolph J. Penn, D.C. is also provided on request at the main administration desk of his practice. This Notice of Privacy Practices also describes my rights and Dr. Penn's duties with my respect to my protected health information.

Randolph J. Penn, D.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Patient Signature or Responsible Party Date

_____

Name of Patient or Responsible Party

_____

Description of Responsible Party