Clear Choice Natural Healthcare

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Troy Michigan 48098
Telephone (248) 879-1900 Fax (248) 879-7305
www.**CCNHC**.com

Confidential Patient Information-**PLEASE PRINT** Date:_____

FULL NAME:_____

NAME SPOUSE/GUARDIAN_____

ADDRESS:_____
Residence and mailing City State Zip

Email Address:_____ _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

AGE:_____BIRTHDATE:_____/_____/_____ GENDER: FEMALE ____ MALE ____ MARITAL STATUS: M S W D

HEIGHT_____ WEIGHT_____ PREGNANT: Yes No

OCCUPATION_____ EMPLOYER _____

RESPONSIBLE PARTY EMPLOYED AT:_____

EMPLOYERS
ADDRESS:_____PHONE:_____

NAME/ADDRESS OF NEAREST
RELATIVE (not living with you)_____

REFERRED BY?_____

CHIEF COMPLAINT

_____

OTHER TREATMENTS

_____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL?

1. NAME_____ADDRESS_____

WHEN_____REASON_____

2. NAME_____ADDRESS_____

WHEN_____REASON_____

3. NAME_____ADDRESS_____

WHEN_____REASON_____

LIST CHIROPRACTORS YOU HAVE SEEN

1.NAME_____ADDRESS_____

WHEN_____REASON_____

2.NAME_____ADDRESS_____

WHEN_____REASON_____

LIST ALL MEDICATIONS AND/OR DIETARY SUPPLEMENTS YOU ARE CURRENTLY TAKING

1. WHAT _____ FREQUENCY _____ DR _____
2. WHAT _____ FREQUENCY _____ DR _____
3. WHAT _____ FREQUENCY _____ DR _____
4. WHAT _____ FREQUENCY _____ DR _____

SURGERY: (PLEASE INCUDE ALL SURGERIES)

1. TYPE _____ WHEN _____ DR/HOSP _____
2. TYPE _____ WHEN _____ DR/HOSP _____
3. TYPE _____ WHEN _____ DR/HOSP _____
4. TYPE _____ WHEN _____ DR/HOSP _____
5. TYPE _____ WHEN _____ DR/HOSP _____

ACCIDENTS/INJURIES: (ESPECIALLY THOSE RELATED TO YOUR PRESENT PROBLEMS)

1. TYPE _____ WHEN _____ HOSPITALIZED? YES NO
2. TYPE _____ WHEN _____ HOSPITALZIED? YES NO
3. TYPE _____ WHEN _____ HOSPITALIZED? YES NO
4. TYPE _____ WHEN _____ HOSPITALIZED? YES NO
5. TYPE _____ WHEN _____ HOSPITALIZED? YES NO

WHAT IS YOUR USE OF THE FOLLOWING?

	NONE	LIGHT	MODERATE	HEAVY
1. CIGARETTES	_____	_____	_____	_____
2. COFFEE	_____	_____	_____	_____
3. ALCOHOL	_____	_____	_____	_____
4. SOFT DRINKS	_____	_____	_____	_____
5. SALT	_____	_____	_____	_____
6. SUGAR	_____	_____	_____	_____

APPROXIMATE DATE OF THE FOLLOWING CONDITIONS YOU HAVE HAD BEFORE OR NOW HAVE:

ALLERGY	_____	EMPHYSEMA	_____	NUMBNESS	_____
ALCOHOLISM	_____	EPILEPSY	_____	PLEURISY	_____
ANEMIA	_____	GALL BLADDER	_____	PNEUMONIA	_____
ARTERIOSCLEROSIS	_____	GOUT	_____	POLIO	_____
ARTHRITIS	_____	HIGH BLOOD PRESSURE	_____	HEADACHES	_____
ASTHMA	_____	HEART TROUBLE	_____	• STRESS	_____
BACKACHES	_____	HEART ATTACK	_____	• SINUS	_____
CANCER	_____	LOW BLOOD SUGAR	_____	• MIGRAINE	_____
CONVULSIONS	_____	MALARIA	_____	RHEUMATIC FEVER	_____
CONSTIPATION	_____	MENSTRUAL CRAMPS	_____	RINGING IN EARS	_____
COLD SORES	_____	IRREGULAR PERIODS	_____	STROKE	_____
DIABETES	_____	MEASLES	_____	TUBERCULOSIS	_____
DIARRHEA	_____	MISSCARRIAGE	_____	THYROID PROBLEMS	_____
DIGESTIVE DISORDERS	_____	MULTIPLE SCLEROSIS	_____	ULCERS	_____
DIZZINESS	_____	MUMPS	_____	VENEREAL DISEASE	_____
ECZEMA	_____	NERVOUSNESS	_____	WHOOPING COUGH	_____
				OTHER	_____

NAME OF SPOUSE_____

DESCRIBE HEALTH OF SPOUSE: _____ NUMBER OF CHILDREN, IF ANY _____

NAME OF CHILD	AGE	SEX	ANY PHYSICAL CONDITIONS OR CONCERNS?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

WHAT CAN WE DO TO MAKE YOU HAPPIER?

_____

_____

ARE YOU INSURED? YES NO COMPANY_____

PAYMENT IS EXPECTED AT TIME OF VISIT.

PLEASE READ CAREFULLY

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGMENT BETWEEN MY INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT CLEAR CHOICE NATURAL HEALTHCARE WILL ASSIST IN PREPARING ANY NECESSARY FORMS AND REPORTS FOR MY INSURANCE COMPANY. ANY AMOUNT AUTHORIZED BY ME TO BE PAID DIRECTLY TO CLEAR CHOICE NATURAL HEALTHCARE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT FOR ALL SERVICES RENDERED TO ME.

NAME OF PERSON RESPONSIBLE FOR PAYMENT: _____

PATIENTS SIGNATURE _____ DATE _____

GUARDIAN SIGNATURE
AUTHORIZING CARE _____ DATE _____