Welcome To Scarffe Chiropractic, P.C.
(616) 383-1021

Name:	**Today's Date:**	
What You Prefer to be Called:		
Mailing Address:	**City:**	**ZIP:**
Home Phone:	**Work:**	**Cell:**
Email Address (newsletter & appointment info):		
Birth Date:	**Age:**	**SS#:**
How did you learn about our office:		
Marital Status: ☐ Married ☐Single ☐Widowed ☐ Divorced		
Spouse's Name:		
Name(s) & Age(s) of Children:		
Occupation:		
Recent Work-Related Injury? ☐ Yes ☐ No	**Recent Auto Accident? ☐ Yes ☐ No**	
Previous Chiropractic Care? ☐ Yes ☐ No	**Approximate Last Visit Date:**	

Please check reasons for pursuing chiropractic care:

____ I'm continuing ongoing care from another chiropractor.

____ I'm interested in wellness and natural health care.

____ I have a specific condition or conditions that concern(s) me.

Primary Reason:_____

Secondary Reason:_____

Other factors contributing to the primary and secondary reasons: _____

_____

Goals: One activity you are currently unable to do, but would like to accomplish in the next:

3 months:_____

6 months:_____

Chief Complaint: _____

Location of Complaint: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other_____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where?_____

Do you have any numbness or tingling in your body? Where?_____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

Previous interventions, treatments, medications, surgery, or care you've sought for your complaint:

_____

_____

Past Health History:

A. Previous illnesses you've had in your life:

_____

B. Previous injury or trauma:_____

_____

Have you ever broken any bones? Which? _____

C. Allergies _____

D. Medications:

Medication	Reason for taking
_____	_____
_____	_____
_____	_____

E: Surgeries:

Date	Type of Surgery
_____	_____
_____	_____

F: Females/Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome
_____	_____
_____	_____
_____	_____

What was the date of the beginning of your last menstrual period?

_____

Social and Occupational History:

A. Level of Education:

☐ high school ☐ some college ☐ college graduate ☐ post graduate studies

B. Job description:

_____

C. Work schedule:

_____

D. Recreational activities:

_____

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

Family Health History:

Check *the following conditions that YOU have had.* ***Circle*** *conditions that are common to FAMILY MEMBERS.*

AIDS	Alcoholism	Cancer	Diabetes	Epilepsy	Hyper/Hypothyroidism
Heart Disease	Lung Disease	Scoliosis	Stroke	Ulcers	Multiple Sclerosis

Deaths in immediate family:

Cause of parents or siblings death	Age at death
_____	_____
_____	_____
_____	_____

In order for us to better understand your current level of health, please check any of the following body signals which you have or have had previously:

☐ Headaches/Migraines	☐ Asthma	☐ Sleep Problems	☐ Menstrual Problems	☐ Weight Problems
☐ Postural Imbalance	☐ Gas/Bloating	☐ Dizziness/Fainting	☐ Ringing in Ears	☐ Allergy/Sinus Poblems
☐ Bladder Trouble	☐ Ear Infection	☐ Frequent Colds	☐ Arthritis	☐ Intestinal Problems
☐ High Blood Pressure	☐ Fatigue	☐ Short leg/Orthotics	☐ Menopausal Symptoms	☐ Glasses/Contacts
☐ Depression	☐ Anxiety			

The Stress Test:

The following areas of stress can cause mis-aligned vertebrae (subluxation). Which of these stresses do you recognize from your life currently or from your childhood?

Physical/Emotional/Chemical Stress:

□Birth Trauma
□Car Accidents
□Physical Abuse
□Work Injuries
□Sleeping on Stomach
□Carrying Heavy Purse/Backpack/Child
□Driving for Many Hours
□Children Stress
□Relationship Stress
□Quick Tempered
□Poor Diet/Excessive Sugar
□Artificial Sweeteners
□Over-the-Counter Drugs (ex. Tylenol/Motrin)
□Slips/Falls
□Sports Injuries
□Poor Posture
□Sitting on a Wallet
□Extensive Computer Work
□Repetitive Lifting/Bending
□Continuous Hours Sitting/Standing
□Career Stress
□Concealed Feelings
□Smoker/Second Hand Smoke
□Caffeine
□Prescription Drugs

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date_____

Doctor's Signature _____ Date _____

Please provide a signature for any of the following that apply to you.

Consent to evaluation and adjustment of a minor child

I _____ being the parent or legal guardian of _____
(print name of consenting adult) (print name of minor)

Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
Consenting Adult's Signature Date

Pregnancy Release (Females of Child-Bearing Age)

I certify that to the best of my knowledge I am not pregnant, and Dr's Chae and Monya Tracy and their associates have my permission to perform an x-ray evaluation. I have been advised that x-rays could be hazardous to an unborn child.

_____ _____
Signature Date