Dr. Lianne Coombe B.A. D.C.
330 S University Ave. Mt Pleasant MI 48858
Phone: 989-400-4477

Thank you for choosing our office!

To ensure your visit with us is a pleasant one, here are the procedures you can expect upon arrival:

Paperwork	Please complete this questionnaire and your health history to help us to get to know you. Dr. Lianne will use this information to help formulate recommendations for your care.
Consultation	You will meet Dr. Lianne and our New Patient Advocate. Dr. Lianne will review your health history and determine if yours is a chiropractic case. You will be informed of any of the fees for office procedures before they are performed.
Examination	Standard physical, orthopedic, neurological, and chiropractic tests will be performed to determine the cause(s) of your subluxations.
Spinal Images	Necessary views may be taken to visualize the location of any spinal problems, neurological interferences, reveal any pathologies, and make your chiropractic care more precise.
Recommendations	Before proper care can be rendered, Dr. Lianne will study your examination findings. Later, you will see x-rays, review your findings, and receive specific care and recommendations from the Doctor.

CONFIDENTIAL PATIENT INFORMATION AND CASE HISTORY

☐ **Mrs.** ☐ **Ms.** ☐ **Miss.** ☐ **Mr.** How would you like to be addressed? _____

Name:_____Date: _____

Address:_____City:_____Postal Code: _____

Home phone:_____Business phone:_____Ext._____Cell phone: _____

Email: _____ Date of Birth:___/___/_____ Gender: _____
m d yy

Age: _____ Weight: _____ lb Number of children: _____Ages: _____

Occupation: _____Employed by: _____

SSN_____

Marital Status ☐single ☐married ☐divorced ☐widowed ☐serious relationship Spouse Name: _____

Whom may we thank for referring you to our office? _____

Name and number of Medical Doctor: _____

Females only, are you pregnant? No☐ Yes☐ Due date: _____

Previous Chiropractic Care: No ☐ Yes☐ Date:_____

Thank you. Please turn the page

What is the **PRIMARY PROBLEM** for which you are seeking chiropractic care? _____

_____

How long have you been dealing with this problem? (Days? Weeks? Months? Years?) _____

How often does this problem affect you? (Daily? Weekly? Monthly)? _____

Circle on a scale of 1-10 how you would rate your discomfort

NO PAIN 1…2…3…4…5…6…7…8…9…10 EXTREME PAIN

How would you describe what you feel?

☐burning ☐sore
☐stabbing ☐tingling ☐radiating ☐dull/aching
☐sharp ☐shooting ☐localized ☐other_____

How has this affected your life? What are you hoping to improve in your life with Chiropractic Care? _____

_____

Is there a **SECONDARY PROBLEM** for which you are seeking chiropractic care?_____

_____

How long have you been dealing with this problem? (Days? Weeks? Months? Years?)_____

How often does this problem affect you? (Daily? Weekly? Monthly)? _____

Circle on a scale of 1-10 how you would rate your discomfort

NO PAIN 1…2…3…4…5…6…7…8…9…10 EXTREME PAIN

How would you describe what you feel?

☐burning ☐sore
☐stabbing ☐tingling ☐radiating ☐dull/aching
☐sharp ☐shooting ☐localized ☐other_____

How has this affected your life? What are you hoping to improve in your life with Chiropractic Care? _____

_____

SPINAL STRESSORS AND TRAUMAS

MOTORIZED VEHICLE ACCIDENTS

Year: _____ Injuries: _____
Year: _____ Injuries: _____
Year: _____ Injuries: _____
Any collisions greater than 25 miles per hour?_____

_____

_____

SPORTS AND RECREATION

What sports do you participate in? _____
Please list notable sports related injuries: _____

_____

_____

FALLS (Childhood and Beyond)

From Heights: _____
Falls Downstairs: _____
Other Falls: _____
Broken Bones/Fractures: _____

MAJOR OPERATIONS/ILLNESSES

Year: _____ Details: _____
Year: _____ Details: _____
Year: _____ Details: _____

OCCUPATIONAL STRESS: my job requires:

☐Long Sitting Periods ☐Heavy Lifting
☐Awkward Positions ☐Repetitive Stress
☐Poor Ergonomics ☐Other:

_____

Thank you. Please turn the page.

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 nervous system, that have resulted in your lowered state of health. At your report of findings, Dr Lianne will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

MEDICATIONS /SUPPLMENTS USED WITHIN THE PAST 6 MONTHS: _____

_____

Past Health: Have you ever suffered from any of the following conditions? Please check all that apply:

- ☐ Thyroid trouble
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Allergies
- ☐ Psoriasis
- ☐ Venereal Disease
- ☐ Heart Attack
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Back Pain
- ☐ Headaches
- ☐ Stomach Ulcers
- ☐ Polio
- ☐ HIV
- ☐ Stroke
- ☐ Emotional Problems
- ☐ Epileptic Seizures
- ☐ Asthma
- ☐ Arthritis
- ☐ Alcoholism
- ☐ Cancer

Present Health: Are you presently affected by any of the following? (Within the past 3 months)

Please check the boxes that apply: O-OCCASIONAL F-FREQUENT C-CONSTANT

MUSCLE AND JOINT	O	F	C
Neck Pain……	☐	☐	☐
Shoulder Pain…….	☐	☐	☐
Low Back Pain……...	☐	☐	☐
Knee Trouble……..	☐	☐	☐
Foot Trouble……...	☐	☐	☐
Arthritis……...	☐	☐	☐
Hernia…….	☐	☐	☐
Spinal Curvature…….	☐	☐	☐
Faulty Posture…….	☐	☐	☐
Sciatica……	☐	☐	☐
Painful Tailbone…….	☐	☐	☐

CARDIOVASCULAR			
Rapid Heart Beat……	☐	☐	☐
High Blood Pressure……...	☐	☐	☐
Low Blood Pressure……	☐	☐	☐
Pain Over Heart……...	☐	☐	☐
Swelling of Ankles…….	☐	☐	☐
Poor Circulation …….	Y	☐	N☐

GENERAL SYMPTOMS			
Fever/Chills/Sweating…….	☐	☐	☐
Fainting……	☐	☐	☐
Convulsions…….	☐	☐	☐
Allergy…….	☐	☐	☐
Skin Problems……..	☐	☐	☐
Colds……	☐	☐	☐
Tremors……	☐	☐	☐
Loss of Balance……	☐	☐	☐

EYE EAR NOSE THROAT	O	F	C
Asthma……..	☐	☐	☐
Sinus Trouble……	☐	☐	☐
Tonsillitis……..	☐	☐	☐
Sore Throat……	☐	☐	☐
Earache……	☐	☐	☐
Deafness……	☐	☐	☐

STRESS SYMPTOMS			
Headache……...	☐	☐	☐
Migraines……...	☐	☐	☐
Dizziness……...	☐	☐	☐
Ringing in Ears…….	☐	☐	☐
Loss of Sleep…….	☐	☐	☐
Blurring of Vision…….	☐	☐	☐
Loss of Concentration……...	☐	☐	☐
Loss of Memory……	☐	☐	☐
Irritable/Nervousness…….	☐	☐	☐
Depression…….	☐	☐	☐
Decreased Energy/Fatigue…….	☐	☐	☐
Tension……...	☐	☐	☐
Numbness or Pins and Needles:			
In Arms/Hands…….	☐	☐	☐
In Legs/Feet…….	☐	☐	☐

RESPIRATORY			
Chronic Cough……...	☐	☐	☐
Spitting Up Phlegm/Blood……	☐	☐	☐
Chest Pain…….	☐	☐	☐
Difficulty Breathing …….	☐	☐	☐

GASTROINTESTINAL	O	F	C
Indigestion…….	☐	☐	☐
Gas Pains……	☐	☐	☐
Nausea or Vomiting……...	☐	☐	☐
Stomach Pains……	☐	☐	☐
Constipation……...	☐	☐	☐
Heartburn……...	☐	☐	☐
Diarrhea…….	☐	☐	☐
Colon Trouble……	☐	☐	☐
Liver Trouble…….	☐	☐	☐
Bladder Trouble…….	☐	☐	☐
Kidney Trouble……...	☐	☐	☐
Blood Stools……...	☐	☐	☐

URINARY			
Painful Urination……	☐	☐	☐
Waking at Night to Urinate……	☐	☐	☐
Increased Urination……	☐	☐	☐
Blood in Urine……...	☐	☐	☐

FEMALES ONLY			
Painful Menstruation…….	☐	☐	☐
Irregular Periods……	☐	☐	☐
Passed Menopause…….	Y	☐	N☐
Menopausal Symptoms…….	☐	☐	☐
Birth Control Pill……...	Y	☐	N☐
Other Birth Control Methods:			

Informed consent to chiropractic adjustments and care

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients of benefits and risks including sprain/strain, rib fracture, disc herniation and with neck problems of the following: there have been very rare incidents of injury to the vertebral artery during the course of treatment. This may have caused strokes or stroke like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays have been performed on you to minimize these risks. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions about this, please ask your chiropractor. If you read the above statement and consent to the exam and treatment if you choose to start care, please sign below.

Signature _____ Date _____

Thank you. Please turn the page.

MY GOALS

We want to make sure we can help you move towards your goals. Your goals can encompass: health, physical, emotional, spiritual and financial factors. Only share what you feel comfortable sharing. You may leave blank if you prefer.

Short Term Goals Where do you want to see yourself in 3-6 months?	*e.g. "I want to sleep better", "I want to wake up without pain", "I want to lose 10lbs"*
Middle Term Goals Where do you want to see yourself in 1-5 years?	*e.g. "I want to compete in a triathlon", "I want to have kids", "I want to get back to my normal activities (please specify)"*
Long Term Goals Where do you want to see yourself in 10-15 years?	*e.g. "I want to have my dream job", "I want to travel the world"*

How **motivated** are you to achieving your **goals**?

Not Motivated				Moderately Motivated					100% Motivated!
1	2	3	4	5	6	7	8	9	10