**Drs. Rob & Sherri Borer**
210 West Michigan Avenue
Saline, MI 48176
734-944-7200

| **Patient Information** | | | | |
|---|---|---|---|---|
| Date: | | | | |
| Last Name: | First Name: | | Nickname? | |
| Birth Date: | Age: | Height: | Weight: | Gender: ☐Male ☐Female |
| Address: | City: | | State: | Zip Code: |
| Email Address: | | Appt. reminders by ☐Email ☐Text | | |
| Home Phone: | | Cell Phone: | | |
| Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated | | | | |
| Emergency Contact: | Relationship: | | Phone: | |
| How did you hear about us? | | | | |
| Your Occupation: | | Employer: | | |
| Primary Physician: | | Physician City/State: | | |
| **Health Insurance** | | | | |
| Name of Insurance Carrier: | | Policy/Group/Contract #: | | |

## Authorization

I certify that I am the patient or legal guardian listed above. I have read/understood all the information on this intake form and certify it to be true and correct to the best of my knowledge. I consent to the collection and use of the information to Borer Family Chiropractic, PLLC. I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic care or management of my condition as the practitioners see fit. I hereby authorize Borer Family Chiropractic, PLLC to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. Verifying insurance benefits does not guarantee payment from my insurance company. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that there is a 24-business hour cancellation policy for new patient and consultation appointments. Failure to comply with the cancellation policy may result in additional charges. A $25 fee will be applied to all NSF checks. By signing below, I agree to the financial policy described above and will adhere to all its practices.

X

Signature of Patient/Legal Representative  Patient Name (Printed)  Date Signed

1. **What symptoms prompted you to seek care today?**

**2. When did these symptoms start? How did they start?**

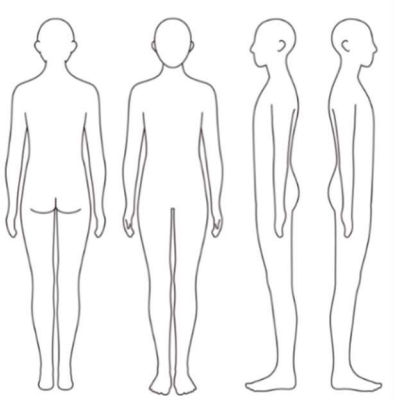
3. **Quality of Symptoms** (What does it feel like?)

☐ Tight ☐ Tingling ☐ Throbbing
☐ Sharp ☐ Numbness ☐ Stabbing
☐ Aching ☐ Heavy ☐ Other
☐ Sore ☐ Burning
☐ Cramps ☐ Shooting

4. **Intensity** (How extreme symptoms – Circle)

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Absent Uncomfortable Agonizing

Please mark area(s) of symptoms:



5. **Duration & Timing** (how often do you feel it?)

☐Constant ☐Comes and goes

6. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate/shoot or travel?)

7. **Aggravating or Relieving Factors** (what makes it better or worse, such as time of day, movements, activities, etc.)

**What tends to lessen the problem?**

**What tends to worsen the problem?**

8. **Prior Interventions**
(What have you done to relieve the symptoms?)

☐ Prescription Medications ☐ Ice
☐ Over-the-counter drugs ☐ Heat
☐ Chiropractic
☐ Other:

9. **What else should we know about your current condition?**

10. **Have you had X-ray or MRI studies for this condition?** ☐Yes ☐No

11. **Do you have a secondary complaint?**

12. **Prior illnesses, operations, injuries, or treatments:**

13. **Medications/Supplements:**

**Social History** (tell me about your health habits)

| Allergies: | Tobacco Use: ☐Daily ☐Occasionally ☐Never |
|---|---|

Exercise? ☐Yes ☐No What kind? How often?

**Personal Incident History** *Briefly Explain:*

| | |
|---|---|
| Broken Bones? ☐Yes ☐No | |
| Been in an Auto Accident? ☐Yes ☐No | |

**Health History:** **check here if NONE**: ☐

| You / Family | | You / Family | | You / Family | |
|---|---|---|---|---|---|
| ☐ ☐ | Diabetes | ☐ ☐ | Thyroid Disease | ☐ ☐ | Cardiovascular Disease |
| ☐ ☐ | Heart Attack | ☐ ☐ | Alzheimer's | ☐ ☐ | Osteoporosis or Osteopenia |
| ☐ ☐ | Stroke | ☐ ☐ | Osteo-Arthritis | ☐ ☐ | Rheumatoid Arthritis |
| ☐ ☐ | Multiple Sclerosis | ☐ ☐ | Gastro-Intestinal | ☐ ☐ | High Cholesterol Controlled by Meds? ☐Yes ☐No |
| ☐ ☐ | Parkinson's | ☐ ☐ | Kidney Disease | ☐ ☐ | High Blood Pressure Controlled by meds? ☐Yes ☐No |
| ☐ ☐ | Headache | ☐ ☐ | Liver Disease | ☐ ☐ | Fibromyalgia &/or Chronic Fatigue Syndrome |
| ☐ ☐ | Migraine | ☐ ☐ | Asthma | ☐ ☐ | HIV/AIDS |

☐ ☐ Cancer: _____

☐ ☐ Other:

**Pain Intensity**: (please mark one box per row)

| In the past 7 days… | No pain | Mild | Moderate | Severe | Very severe |
|---|---|---|---|---|---|
| How intense was your pain at its **worst**? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| How intense was your **average** pain? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| What is your level of pain **right now**? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |

**Pain Interference**: (please mark one box per row)

| In the past 7 days… | Not at all | A little bit | Somewhat | Quite a bit | Very much |
|---|---|---|---|---|---|
| How much did pain interfere with your day-to-day activities? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| How much did pain interfere with work around the home? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| How much did pain interfere with your ability to participate in social activities? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| How much did pain interfere with your household chores? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |

## Informed Consent for Chiropractic Care

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic care or management of my condition(s), on me (or on the patient named below, for whom I am legally responsible).

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

I understand and am informed that, though infrequent, as with any health procedure, there are certain complications which may arise during chiropractic health care. These complications include, but are not limited to, soreness, fractures, disc injuries, strokes, dislocations, and sprains. These complications are extremely rare. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

Neither the practice of chiropractic nor medicine is an exact science, but relies upon information related to the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases. There has been no promise, implied or otherwise, of a cure for any symptom, disease, or condition as a result of care in this office.

I understand that there are other forms of treatment, including drugs and surgery, which could be treatment options for my condition, but at this time, I choose chiropractic care.

X

| Signature of Patient/Legal Representative | Patient Name (Printed) | Date Signed |
|---|---|---|

**Pregnancy Release (Women Only):**

This is to certify that to the best of my knowledge I am not pregnant and the above office, doctors and/or staff have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

X

| Signature of Patient<br>(Or Legal Representative | Date Signed |
|---|---|