

Patient Introduction

COUSINEAU CHIROPRACTIC
14550 KING RD
RIVERVIEW, MI. 48193
734-479-1880

Date _____ Name _____ Age _____ SS# _____ Pt.# _____

CURRENT Health Complaints (Symptoms) _____

What Day Did Symptoms Start (Date) _____ Duration _____

How Did It Happen? _____

Are you claiming a Auto Accident Work Comp 3rd Party Liability (PI) Injury Date _____

What makes it better? Nothing Bending Lifting Sitting Standing Moving Resting

What makes it worse? Nothing Bending Lifting Sitting Standing Moving Resting

Please Mark The Problem Areas With The Following Letter:

A - Ache

P - Pain

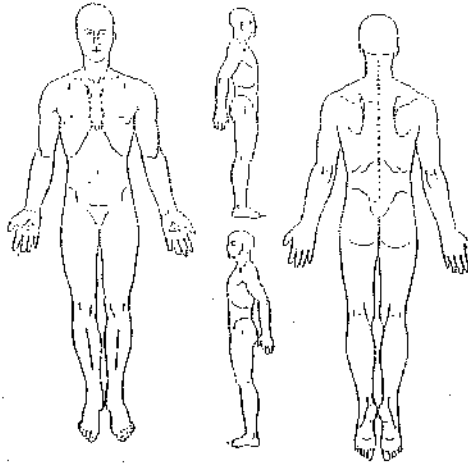
N - Numbness

T - Tingling

B - Burning

S - Stabbing

R - Radiating



List Surgeries _____

Medications _____

CHECK CURRENT AND PAST PROBLEMS

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Neck Complaints | <input type="checkbox"/> Wear Glasses | <input type="checkbox"/> Liver Trouble | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Gall Bladder Trouble | <input type="checkbox"/> Bladder Trouble |
| <input type="checkbox"/> Shooting Head Pain | <input type="checkbox"/> Grating In Neck | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Tight Shoulders | <input type="checkbox"/> Low Back Complaints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Pins & Needles in | <input type="checkbox"/> Pinched Nerves in Back | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Arms and Hands | <input type="checkbox"/> Pins & Needles in legs | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Throat Inflammation | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Pain in Legs & Feet | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Mid Back Complaints | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Painful joints | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Twitching of Face | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> T.B. (Tuberculosis) | <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Nerves/Nervousness |
| <input type="checkbox"/> Head Feels Heavy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Intestinal Gas | <input type="checkbox"/> Inner Tension |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Stomach Troubles | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Menstrual Cramps & Pain | <input type="checkbox"/> Arthritis |

Women:
Are you pregnant? _____ If yes, (congratulations!) when are you due? _____
Are you nursing? _____