

ATIYEH WELLNESS & INJURY CENTER

247 N. Main St.
Plymouth, MI 48170
(734) 455-2145
FAX: (734) 455-2825

Case Number _____

Today's Date _____

CA _____ DC _____

Tell Us About You

Title: _____ First: _____ MI: _____ Last: _____
Nickname: _____ Birth date: _____ Age: _____ Sex: Male Female
Current address: _____
City: _____ State: _____ Zip: _____
SS #: _____ - _____ - _____ Email: _____
Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____ Ext: _____
Mobile Phone: _____ - _____ - _____ Preferred contact: Home Work Cell
Referred by: _____
Marital status: Single Divorced Widowed Married to: _____
of children: _____ Ages of children: _____
 Full-time employment Part-time employment Self-employed Unemployed Retired
Occupation: _____ Employer: _____
 Full-time student Part-time student School name: _____
Alternate address: _____
City: _____ State: _____ Zip: _____ Parents/Other: _____
Emergency Contact: _____ Phone: _____ - _____ - _____
Your relationship to emergency contact: _____

Tell Us Why You're Here

What is the primary reason for your visit? _____

Is this due to a: Automobile accident Work-related injury Personal injury case None

When did your pain/symptoms begin (include date if possible)? _____

The overall severity of your complaints/concerns is:
 Mild Mild to moderate Moderate Moderately severe Severe

The overall frequency is: Occasional Intermittent Frequent Constant

On a scale of 0 to 10, how would you rate your pain/symptoms today? (please circle a number below)
None = 0 1 2 3 4 5 6 7 8 9 10 = Worst possible

If your symptoms change, when are they worse: Morning Afternoon Evening Night NA

Are your symptoms/pain getting: Better Worse Staying the same

Your Health Habits and Lifestyle

- Which is your dominant hand: Left Right Ambidextrous
- Which of the following best describes your stress level: None Minimal Moderate Extreme
- Do you smoke? No Yes—How much: _____
- Do you exercise? No Yes—How often: _____
- How many caffeinated drinks do you consume: _____ per day
- How many alcoholic drinks do you consume: _____ per week
- Do you have weight issues? No Yes
- Are you currently taking any vitamins or nutritional supplements: No Yes—please indicate which one/s:

- Do you have any heavy metal toxicity? No Yes—_____ Unknown
- Do you have any "silver" or amalgam dental fillings in your mouth? No Yes Unknown
- Do you have any body piercings (aside from ear piercings)? No Yes
- What type of water is in your home? City Well—Date last tested: _____
- Do you sleep on your stomach? No Yes
- Do you carry a wallet in your back pocket? No Yes
- Do you have any scars from injury or surgery? No Yes—_____
- How often do you consume processed or prepared foods? Occasionally Frequently Usually
- Are the cosmetics and/or personal grooming products you use: Mainstream All natural or organic
- Are the cleaning products and laundry detergent in your home: Mainstream All natural or organic
- WOMEN ONLY:** To your knowledge are you pregnant? No Yes—Due date: _____

Other Health Care Providers

- Have you ever been to a doctor of chiropractic before? No Yes—How long ago? _____
- Name of previous chiropractor: _____
- City: _____ State: _____
- Do you see a medical doctor or osteopath? No Yes—Date of last visit: _____
- Name of medical doctor: _____
- City: _____ State: _____

Communication is Key to a Positive Relationship

- Is there anything else you would like us to know? No Yes—_____
- _____
- _____
- _____
- _____

Signature: _____ Date: _____ Case: _____

Activities of Daily Living and Work

Please indicate which activities of daily living are compromised by your current state of health:

General:	<input type="checkbox"/> Walking	<input type="checkbox"/> Standing	<input type="checkbox"/> Running	<input type="checkbox"/> Sports
	<input type="checkbox"/> Sitting	<input type="checkbox"/> Lifting children	<input type="checkbox"/> Bending	<input type="checkbox"/> Recreational activities
	<input type="checkbox"/> Climbing stairs	<input type="checkbox"/> Reading	<input type="checkbox"/> Lying in bed	<input type="checkbox"/> Getting into/out of an automobile
	<input type="checkbox"/> Chewing	<input type="checkbox"/> Swimming	<input type="checkbox"/> Using keyboard	<input type="checkbox"/> Sewing or crafts
	<input type="checkbox"/> Kneeling	<input type="checkbox"/> Playing instrument	<input type="checkbox"/> Exercising	<input type="checkbox"/> _____
	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Using telephone	<input type="checkbox"/> Sitting in recliner	
Housework:	<input type="checkbox"/> Doing laundry	<input type="checkbox"/> Vacuuming	<input type="checkbox"/> Ironing	<input type="checkbox"/> Caring for pets
	<input type="checkbox"/> Making beds	<input type="checkbox"/> Washing dishes	<input type="checkbox"/> Carrying groceries	<input type="checkbox"/> Cooking
Yardwork:	<input type="checkbox"/> Mowing lawn	<input type="checkbox"/> Raking leaves	<input type="checkbox"/> Gardening	<input type="checkbox"/> Shoveling snow
Personal grooming:	<input type="checkbox"/> Combing hair	<input type="checkbox"/> Shaving	<input type="checkbox"/> In/out of bathtub	<input type="checkbox"/> Brushing teeth
Travel:	<input type="checkbox"/> Driving a car	<input type="checkbox"/> Riding in a car	<input type="checkbox"/> _____	<input type="checkbox"/> _____

How often does your job involve lifting? Never Occasionally Frequently Constantly

Other job requirements (please check all that apply): Bending Carrying Stooping

Twisting Turning Walking Other: _____

What is your primary work position? Seated Standing Other: _____

Sickness, Injury and Accident History (please include dates and descriptions)

Accidents (include automobile, work-related, personal injury, slip and fall, or any serious injury): _____

Prior illnesses (other than colds and flu): _____

Surgeries and hospitalizations: _____

Are you currently taking ANY over-the-counter medication: No Yes—list name and for what condition.

Are you currently taking ANY prescription medication: No Yes—list name and for what condition.

<u>DRUG</u>	<u>CONDITION</u>	<u>DRUG</u>	<u>CONDITION</u>	<u>DRUG</u>	<u>CONDITION</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Remember to list ALL drugs including: aspirin, antibiotics, insulin, birth control pills, blood pressure pills, etc.