NEW PATIENT MEDICAL FORM

Check one: Dr. Tent | Dr. Gill | Dr. Senechal

Name:________________________________ Date of scheduled appointment: ___________

Address:____

City:____________________________________State:____________Zip:________________

Primary Phone:______________________________Email: ____________________________

Date of Birth:_______________Gender:________

Name of Your Employer:____

Type of Work:____

Check if you are: Single Married Widowed Divorced Separated

Name & telephone number of person to contact in case of emergency:____________________

____

Name of Spouse or Guardian:____

Spouse or Guardian's employer:____

Referred to this office by: ____

LIST YOUR MAJOR PRESENT HEALTH COMPLAINT (IN ONE SENTENCE):_______________

____

____

DURATION OF PRESENT CONDITION:____

Have you been treated before for this problem? ☐ No ☐ Yes

If yes, by ☐ Physician ☐ Chiropractor ☐ Physical Therapist ☐ Osteopath

☐ Other:____

What did they do and/or recommend?____

What was their diagnosis?____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST:

Anemia	Epilepsy	Liver Disease	Pneumonia
Appendicitis	Goiter	Malaria	Rheumatic Fever
Bronchitis	Gout	Measles	Scarlet Fever
Cancer	Heart Disease	Mental Disorders	Stroke
Chicken Pox	Hepatitis	Migraine Headaches	Smallpox
COPD	High Cholesterol	Multiple Sclerosis	Tonsilitis
Diabetes	Heart Attack	Mumps	Tuberculosis
Diphtheria	Hernia	Pleurisy	Venereal Infection
Eczema	Kidney Disease	Polio	Whooping Cough

Please check all of the symptoms you have NOW.

GENERAL SYMPTOMS:
Headache
Fever/Sweats
Chills
Fainting
Dizziness
Convulsions
Weight gain
Loss of weight
Loss of sleep
Bruises easily
Leg Cramps

E.N.T.:
Failing vision
Crossed eyes
Eye pain
Deafness
Earache
Nosebleeds
Sore throat
Asthma
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Sinus infection
Nasal drainage
Enlarged glands

SKIN:
Acne
Itching
Dryness
Rash
Varicose veins
Hives
Sores

RESPIRATORY:
Cough
Spitting-up phlegm/blood
Difficulty breathing/wheezing

CARDIOVASCULAR:
Rapid/Slow heartbeat
High/Low blood pressure
Pain over heart
Swelling of ankles
Poor circulation
Chest pain
Shortness of Breath
Heart Palpitations

RENAL/URINARY:
Frequent urination
Painful urination
Blood in urine
Kidney stones
Inability to control urine

GASTROINTESTINAL:
Poor appetite
Difficult digestion
Acid Reflux
Belching or gas
Nausea/Vomiting
Distention of abdomen
Constipation
Diarrhea
Hemorrhoids
Intestinal worms
Liver trouble
Gall bladder trouble
Colitis/Diverticulitis

FOR WOMEN ONLY:
Are you pregnant? Yes or No
Excessive flow
Hot flashes
Irregular cycle
Cramps
Previous miscarriage
Vaginal discharge
Breast Lumps/Tenderness
☐ Other:____________

FOR MEN ONLY:
Breast lumps
Erection difficulties
Lump in testicle
Sores on genitalia
☐ Other:____________

MENTAL HEALTH:
Alcoholism
Obsessive behavior
Perfectionist/controlling
Exercise/electronics addict
Negative/dark thoughts
Irritable/impatient/angry
Dislike of dark/fall weather
Depressed/flat/bored
Lack drive & motivation
Can’t focus or concentrate
Thrill seeker/risk taker
No sex drive
Needs caffeine or “uppers”
Trouble relaxing/loosening up
Feel weak or shaky
Feels worse skipping meals
Overly sensitive
Hard to get over pain or losses
Uses drugs (pharma/recreation)
Difficulty falling/staying asleep
Under great emotional stress
Had a nervous breakdown
Treated for a mental disorder
Overwhelmed/can’t get it done
Unrealistic fears

HABITS:
☐ Coffee/Tea
☐ Alcohol
☐ Tobacco/Marijuana
☐ Exercise

NECK, BACK, EXTREMITIES: Please check all of the symptoms you have NOW.

NECK:
Pain in neck
Neck stiffness
Neck weakness
Muscle spasms in neck
Grinding/popping sounds in neck

MID-BACK:
Mid-back pain
Mid-back stiffness
Pain from front to back
Muscle spasms in mid-back

LOW BACK:
Low back pain
Low back stiffness
Low back weakness
Muscle spasms in low back

ARMS & HANDS:
Pain in elbow ☐ Right ☐ Left
Pain in hand ☐ Right ☐ Left
Pain in fingers ☐ Right ☐ Left
Pins & needles in fingers ☐ Right ☐ Left
Numbness in arm ☐ Right ☐ Left
Weakness of arm/hand ☐ Right ☐ Left

SHOULDERS:
Pain in shoulder joint ☐ Right ☐ Left
Pain across shoulders
Can't raise arm ☐ Right ☐ Left

HIPS, LEGS & FEET:
Pain in buttocks ☐ Right ☐ Left
Pain in hip joint ☐ Right ☐ Left
Pain down leg ☐ Right ☐ Left
Pain in ankle/foot ☐ Right ☐ Left
Weakness of leg ☐ Right ☐ Left

Accidents or falls (Please Describe):____

____

Fractures or dislocations: ____

____

PAST HEALTH HISTORY

Surgeries/artificial joints/medical devices:______________________________________

____

Organs/Glands removed: ____

Vaccinations and injections received:

☐ Diphtheria ☐ Polio ☐ Tetanus ☐ Typhoid ☐ Smallpox ☐Influenza ☐Covid

☐ Spinal tap or injections ☐ Blood Transfusions

☐ Other:____

Medications you are currently taking: ____

____

____

Allergies/Dietary Restrictions: ____

____

FAMILY HEALTH HISTORY

RELATION:	NAME:	AGE:	SIGNIFICANT ILLNESSES:

Father:____

Mother:____

Brother:____

Brother:____

Sister:____

Sister:____

Child:____

Child:____

Child:____

ANY ADDITIONAL INFORMATION YOU FEEL WE SHOULD KNOW, PLEASE ADD HERE:

____

____

____

FINANCIAL RESPONSIBILITY

Who is responsible for your bill: ☐ Self ☐ Insurance ☐ Employer (Worker's Comp.)
☐ Automobile Insurance ☐ Other:____________________

Policy holder's name (if different from yourself):______________________________

Policy holder's date of birth:____

*Any charges not covered by insurance are the responsibility of the patient. The patient is responsible for meeting the payment requirements of the insurance policy regarding deductibles and co-payments, and also payment for services not covered by the insurance policy.

________________________________ ____________________

Patient's Signature Date of Signature

IF PATIENT IS A MINOR, PARENT OR LEGAL GUARDIAN MUST SIGN FORM

Diverse Health Services PLLC

R.E. Tent, D.C., N.D., Ph.D.
Craig Gill, B.S., D.C.
Jeff Senechal, D.C., C.F.M.P.
24230 Karim Blvd, Suite 130
Novi, MI 48375
(248) 477-0380

It has been explained to me, and I understand that R.E. Tent D.C., Craig Gill D.C., & Jeff Senechal D.C. are Chiropractors and not medical or osteopathic physicians. As a result, this practice and the care provided is limited to that which is permitted by State Law. We do not provide the type of care or treat conditions that fall within the scope of practice of Medical Doctors, and do not treat or offer cures for diseases or illnesses such as cancer, diabetes, or other similar conditions.

R.E. Tent D.C., Craig Gill D.C., and Jeff Senechal D.C. may provide nutritional advice or support. I understand that this advice and support is provided for general health and is not offered as treatment for a disease or illness. Medical doctors or specialists must treat any disease or illness that I may have.

I have read this statement, I have had the opportunity to discuss it with the staff, and agree with it. I acknowledge that R.E. Tent D.C., Craig Gill D.C., and Jeff Senechal D.C. are not treating me for any disease or illness and agree not to hold them responsible for any such condition.

With this knowledge, I freely and willingly consent to the recommended course of treatment.

Signed:____________________________________ Date:__________________

Staff:_____________________________________ Date:_________________

DIVERSE HEALTH SERVICES, PLLC
24230 KARIM BLVD, SUITE 130, NOVI MI 48375
PHONE(248) 477-0380 FAX (248)477-8320

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ________________________________, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and accreditation.

____

{Please Print Name}

____

{Signature}

____

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)____

____

Staff Signature Date