NEW PATIENT MEDICAL FORM

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

Name:_____ Date of scheduled appointment: _____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email: _____ Skype ID:_____

Date of Birth:_____ Gender:_____ Height:_____ Weight:_____

Social Security Number:_____

Name of Your Employer:_____

Type of Work:_____

Check if you are: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Name and telephone number of person to contact in case of emergency:_____

_____

Name of husband or wife:_____

Husband or wife's employer:_____

Referred to this office by: _____

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

_____

DURATION OF PRESENT CONDITION (HOW LONG):_____

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:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Breast Lumps
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hernia
- ☐ Influenza
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Mental Disorders
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Polio
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Smallpox
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Infection
- ☐ Whooping Cough

Other:_____

Please Check all of the following symptoms you have had PREVIOUSLY.

Please (Circle) all of the symptoms you have (NOW)

GENERAL SYMPTOMS

- ☐ Headache
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Numbness / pain in arms, hands, or legs
- ☐ Allergy
- ☐ Wheezing
- ☐ Weight gain
- ☐ Loss of weight
- ☐ Loss of sleep
- ☐ Bruises easily
- ☐ Neuralgia

E.E.N.T.

- ☐ Failing vision
- ☐ Nearsightedness
- ☐ Farsightedness
- ☐ Crossed eyes
- ☐ Eye pain
- ☐ Deafness
- ☐ Earache
- ☐ Ear noises
- ☐ Ear discharge
- ☐ Nosebleeds
- ☐ Nasal obstruction
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Asthma
- ☐ Dental decay
- ☐ Gum trouble
- ☐ Frequent colds
- ☐ Enlarged thyroid
- ☐ Tonsillitis
- ☐ Sinus infection
- ☐ Nasal drainage
- ☐ Enlarged glands
- ☐ Hay fever

SKIN

- ☐ Skin Eruptions
- ☐ Itching
- ☐ Dryness
- ☐ Boils
- ☐ Varicose veins
- ☐ Sensitive skin
- ☐ Hives or allergy
- ☐ Sores that wouldn't heal

RESPIRATORY

- ☐ Chronic cough
- ☐ Spitting-up phlegm
- ☐ Spitting-up blood
- ☐ Chest pain
- ☐ Difficulty breathing

CARDIOVASCULAR

- ☐ Rapid heartbeat
- ☐ Slow heartbeat
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Previous heart stroke
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Paralytic stroke
- ☐ Chest pain

GENITOURINARY SYMPTOMS

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection of stones
- ☐ Bed wetting
- ☐ Inability to control urine
- ☐ Prostate trouble

GATROINTESTINAL

- ☐ Poor appetite
- ☐ Difficult digestion
- ☐ Excessive hunger
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Pain over stomach
- ☐ Distention of abdomen
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colon trouble
- ☐ Hemorrhoids (piles)
- ☐ Intestinal worms
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Jaundice
- ☐ Colitis

FOR MEN ONLY

- ☐ Breast lumps
- ☐ Erection difficulties
- ☐ Lump in testicle
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other:_____

FOR WOMEN ONLY

- ☐ Are you pregnant?___
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Cramps or backache
- ☐ Previous miscarriage
- ☐ Vaginal discharge
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Painful menstrual periods
- ☐ Other:_____

NECK, BACK, EXTREMITIES: Please Check all of the following symptoms you had previously.

Please Circle all of the symptoms you have NOW.

NECK

- ☐ Pain in neck
- ☐ Neck stiffness
- ☐ Neck weakness
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding/popping sounds in neck

SHOULDERS

- ☐ Pain in shoulder joint ☐ Right ☐ Left
- ☐ Pain across shoulders
- ☐ Can't raise arm ☐ Right ☐ Left
  - ☐ Above shoulder level
  - ☐ Over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder ☐ Right ☐ Left

MID-BACK

- ☐ Mid-back pain
- ☐ Mid-back stiffness
- ☐ Pain between shoulder blades
- ☐ Pain from front to back
- ☐ Muscle spasms in mid-back

LOW BACK

- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Low back weakness
- ☐ Pinched nerve in low back
- ☐ Low back feels out of place
- ☐ Muscle spasms in low back

ARMS & HANDS

- ☐ Pain in upper arm ☐ Right ☐ Left
- ☐ Pain in elbow ☐ Right ☐ Left
- ☐ Pain in forearm ☐ Right ☐ Left
- ☐ Pain in hand ☐ Right ☐ Left
- ☐ Pain in fingers ☐ Right ☐ Left
- ☐ Pins & needles in fingers ☐ Right ☐ Left
- ☐ Numbness in arm ☐ Right ☐ Left
- ☐ Numbness in fingers ☐ Right ☐ Left
- ☐ Weakness of arm ☐ Right ☐ Left
- ☐ Weakness of hand ☐ Right ☐ Left
- ☐ Hands cold ☐ Right ☐ Left

HIPS, LEGS & FEET

- ☐ Pain in buttocks ☐ Right ☐ Left
- ☐ Pain in hip joint ☐ Right ☐ Left
- ☐ Pain down leg ☐ Right ☐ Left
- ☐ Pain in ankle ☐ Right ☐ Left
- ☐ Pain in foot ☐ Right ☐ Left
- ☐ Weakness of leg ☐ Right ☐ Left
- ☐ Weakness of knee ☐ Right ☐ Left
- ☐ Leg cramps ☐ Right ☐ Left

OTHER SYMPTOMS

_____

_____

_____

_____

_____

_____

PAST HEALTH HISTORY

OPERATIONS/SURGERIES AND YEARS PERFORMED: _____

_____

Organs/Glands removed: _____

VACCINATIONS AND INJECTIONS RECEIVED:

☐ Diphtheria ☐ Polio ☐ Tetanus ☐ Spinal tap or injections ☐ Typhoid ☐ Smallpox
☐ Other: _____

HABITS: ☐ Coffee ☐ Tea ☐ Alcohol ☐ Tobacco
☐ Exercise ☐ Hobbies ☐ Sleep (Hours): _____

ACCIDENTS OR FALLS (Please Describe): _____

_____

Fractures or dislocations:_____

_____

Drugs (medications) you are currently taking:_____

_____

Allergies: _____

Have you ever had a nervous breakdown?_____

Have you ever been treated for any mental disorders?_____

Has any member of your family been treated for a mental disorder?_____

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
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

Diverse Health Services PLLC

R.E. Tent, D.C., N.D., Ph.D.
Jeff Senechal, D.C., C.F.M.P.
Craig Gill, B.S., D.C.
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:_____