

Levi J. Pulver, D.C., PLLC
17208 Van Wagoner Rd
Spring Lake, MI 49456
616.604.0744
www.pulverchiropractic.com

New Patient Information

Date : _____ Name: _____

D.O.B. : _____ Email: _____

Email will be used for appointment confirmation, information regarding our office, and special promotions.

Address : _____ City, State, Zip: _____

Home Phone : _____ Cell Phone : _____

Employer/Job Duties: _____ Work Phone: _____

Spouse : _____ Children (names/ages) : _____

Emergency Contact Information: _____

Referred By: Family Friend Phone Book Other :

Which one of our patients shall we thank? _____

Reason you are here: _____

Other Doctors seen for this condition: _____

Who is your general health care practitioner: _____

Contact Information: _____

Is it ok if we send him/her updates on your care? _____

Previous Chiropractor: _____ Were you satisfied with their care? : Yes No

Circle any other symptoms you are experiencing or have experienced in the past:

Headaches	Asthma	Allergies	Arthritis	Sinus Problems
Neck Pain	Neck Stiffness	Stomach Pain	Chest Pain	Shoulder/Arm Pain
Sciatica	Numbness	Stress	Hip/Pelvis Pain	Wellness
Upper Back Pain	Middle Back Pain	Lower Back Pain	Other :	

My Symptoms are due to(circle): Auto Accident Work Accident Home Accident
Sports Injury Gradual Onset

Are you Pregnant? Yes No Due Date: _____

List all surgeries in the last 5 years : _____

Have you ever had spinal surgery? Yes No

List any serious conditions/other health issues the doctor should be aware of: _____

Please list medication (OTC/Prescription) and supplements you are taking: _____

Office Policies: If I am accepted as a patient of Dr. Pulver's, I agree to pay for all services, including services not covered by my insurance company. I also acknowledge, that when I am given explanation of my benefits from the practice, it is not a guarantee of payment. If I suspend (or terminate) my treatment without the doctor's permission, a note will be made in my file with reasons cited. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe money on my account. I also understand that if I came in on a special promotion, those payments can not be submitted to insurance.

Consent to Treat: I understand that no cures are promised (or implied) and results are not guaranteed. I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest. I now authorize Dr. Pulver to proceed with any necessary treatments. I have read Dr. Pulver's office policies and consent to treat information, and I agree with them by signing below:

Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Present Health History

When did your present condition begin?

Gradual Onset

Date: _____

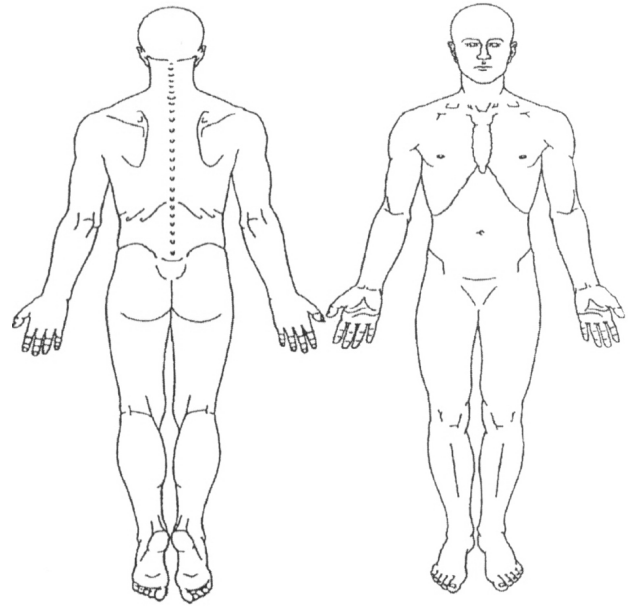
What caused your present condition?

No specific injury

Home Accident

Work Accident

Auto Accident



What happened to cause your present symptoms?

Have you ever had these symptoms before?

No

Yes (date: _____)

Please label the area(s) of today's symptoms

What time of day are your symptoms better?

Morning

Afternoon

Evening

None of the above (constant pain)

What time of day are your symptoms worse?

Morning

Afternoon

Evening

All of the above (constant pain)

What makes your symptoms better?

Rest

Ice packs/Heating pads

Prescription Medications

OTC medications

Other (_____)

What makes your symptoms worse?

Activity (work, repetitive motions)

Ice packs/Heating pads

Driving (or riding) in car

Other (_____)

Patient Health History Worksheet

Significant Past History

Have you ever been hospitalized?

No

Yes (Year: _____ Reason: _____)

Have you had any surgeries?

No

Yes (Year: _____ Reason: _____)

Do you have any significant health problems?

No

Yes (_____)

Family Medical History

Did your father have any health problems?

No

Yes (_____)

Did your mother have any health problems?

No

Yes (_____)

Did your siblings have any health problems?

No

Yes (_____)

Did your grandparents have any health problems?

No

Yes (_____)

Personal History

Do you play any sports or exercise?

No

Yes (_____)

Anything else the doctor should know?

No

Yes (_____)

How many hours do you sleep a night? (_____)

Any concerns about Chiropractic safety?

No

Yes (_____)

How many hours a week do you work? (_____)

Do you drink alcohol?

No

Yes (How Many: _____)