

Levi J. Pulver, D.C., PLLC  
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## 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: \_\_\_\_\_

Do you mind 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: \_\_\_\_\_

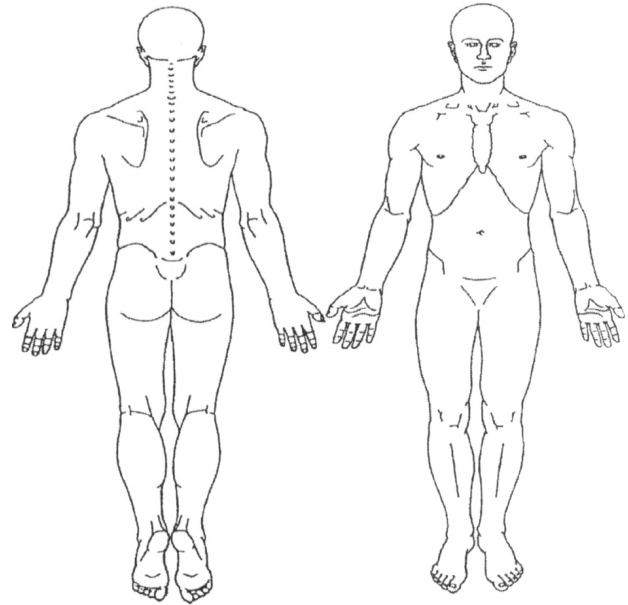
**What caused your present condition?**

No specific injury

Home Accident

Work Accident

Auto Accident



**What happened to cause your present symptoms?**

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**Have you ever had these symptoms before?**

No

Yes (date: \_\_\_\_\_)

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

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**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: \_\_\_\_\_)

**Please take a few minutes to answer these questions so we can help you get better faster.**

**Please circle or fill in your response.**

**How have you taken care of your health in the past?**

Medications	Exercise	Vitamins
Emergency Room	Nutrition/Diet	Chiropractic
Routine Medical	Holistic Care	Other : _____

**How did that work out for you?**

Bad Results	Nothing Changed	Still trying
Some Results	Didn't get worse	Confused
Great Results	Didn't work too long	Other: _____

**How have others been affected by your health condition?**

No one is affected	They tell me to do something
Haven't noticed any problems	People avoid me

**What are you afraid this might be(or beginning) to affect(or will affect)?**

Job	Marriage	Time
Kids	Self-Esteem	Finances
Future Ability	Sleep	Freedom

**Are there health conditions you're afraid this might turn into?**

Heart Disease	Diabetes	Family Health Problems
Cancer	Arthritis	Chronic Fatigue
Depression	Fibromyalgia	Need Surgery

**How has this affected your job, relationships, finances, family, or other activities? \_\_\_\_\_**

\_\_\_\_\_

**What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc) \_\_\_\_\_**

\_\_\_\_\_

**What are you most concerned with regarding your health? \_\_\_\_\_**

\_\_\_\_\_

**Where do you picture yourself in 5-10 years if it isn't taken care of? \_\_\_\_\_**

\_\_\_\_\_

**What would be different without this issue? \_\_\_\_\_**

\_\_\_\_\_

**What do you desire most from working with us? \_\_\_\_\_**

\_\_\_\_\_

**Are you interested in care for the rest of your family? \_\_\_\_\_**