

Welcome To

Van Every Family Chiropractic Center, PLC

4203 Rochester Rd. • Royal Oak, MI 48073 • (248) 616-0900

Dr. Anna Saylor-Wither
 Dr. Laura Vanloon
 Auto Accident

Name _____ Date _____
Last First Middle Initial

Social Security # _____ Choose One: Minor Married Divorced Separated Widowed Single

Address _____ City _____ State _____ Zip _____

Phone _____ Cell _____ Work _____ Email _____

Date of Birth _____ Age _____ Gender _____ **Whom may we thank for your referral?** _____

Occupation _____ Employer's Name & Address _____

Ht. _____ ft. _____ in. Weight _____ Spouse/Guardian _____ Spouse's Employer _____

Children's Names and Ages _____

List your major complaints in order of severity:	What does it prevent you from doing?	List your health goals:
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____

DO YOU HAVE ANY DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, MARK "X"

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting or seizures | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Painful menstruation |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Ringing of ears or earaches | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Irregular menstruation |
| <input type="checkbox"/> Loss of smell - taste | <input type="checkbox"/> Hearing difficulty | <input type="checkbox"/> Anemia | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Hayfever / Allergies | <input type="checkbox"/> Eye / vision trouble | <input type="checkbox"/> Acid reflux or ulcers | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Neck muscle spasm | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Tailbone / sacrum pain |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tightness in shoulder muscles | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Throat trouble | <input type="checkbox"/> Pain in shoulders & arms | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Infections | <input type="checkbox"/> Pins & needles in arms & hands | <input type="checkbox"/> Nerves, nervousness | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Inner tension | <input type="checkbox"/> Slipped disc |
| <input type="checkbox"/> Sleeping trouble | <input type="checkbox"/> Chest pains or rib pains | <input type="checkbox"/> Irritability - moodiness | <input type="checkbox"/> Pinched nerve in back |
| <input type="checkbox"/> Facial pain or palsy | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Prostate trouble | <input type="checkbox"/> Pins & needles in legs |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Depression / anxiety | <input type="checkbox"/> Heart palpitation or heart trouble | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Numbness in legs |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Buttocks pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Dizziness / vertigo | <input type="checkbox"/> Mid back or shoulder blade pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Groin pain |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Constipation | <input type="checkbox"/> Pain in legs and feet |

Family history of any of the above? Yes No If yes, who? _____

List any **accidents or injuries** in the past year: _____

List any injuries between 1 and 10 years: _____

List any injuries over 10 years: _____

List all **surgeries or fractures** and when: _____

List all **medications** and what they're for: _____

Other doctors seen for this condition: _____

Previous chiropractic care? Yes No When? _____ Where? _____

Is your condition a result of your: Employment Auto Accident Personal Injury Other _____

Do you have health insurance? Yes No Company _____ Subscriber's Date of Birth _____

Do you have secondary insurance? Yes No Company _____ Subscriber's Date of Birth _____

SIGNATURE: _____ **DATE:** _____

