Borer Family Chiropractic, PLLC
Drs. Rob and Sherri Borer
210 West Michigan Avenue
Saline, MI 48176
(734) 944-7200

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will help us serve you better.

Patient Information				
Name:			Today's Date:	
Date of Birth:	Age:	Height:	Weight:	Sex:
Address:	City:		State:	Zip Code:
Email:		Preferred Method of Communication: ☐ Email ☐ Text ☐ Phone Call		
Phone:		☐ Home ☐ Cell ☐ Work		
Additional Phone:		☐ Home ☐ Cell ☐ Work		
Marital Status:	Spouse's Name:		Number of Children:	
Emergency Contact:	Relationship:		Phone:	
How did you find out about our office?				
Occupation:		Employer:		
Primary Care Physician:		Physician location:		

Health Insurance	
Name of insurance carrier:	Policy#/Enrollee ID/Contract #:
Company Address:	Company Phone:

Authorization

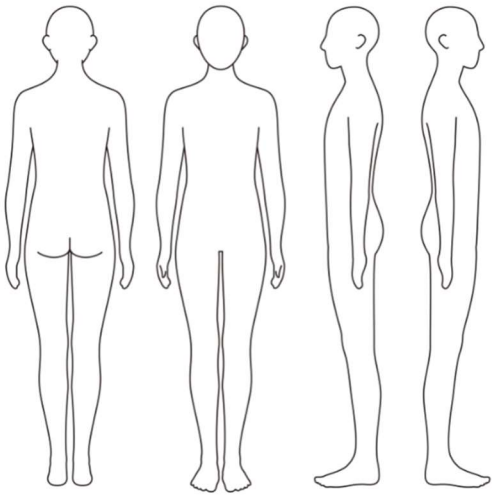
I certify that I am the patient or legal guardian listed above. I have read/understood all the information on this intake form and certify it to be true and correct to the best of my knowledge. I consent to the collection and use of the information to Borer Family Chiropractic, PLLC. I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic care or management of my condition as the practitioners see fit. I hereby authorize Borer Family Chiropractic, PLLC to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. Verifying insurance benefits does not guarantee payment from my insurance company. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that there is a 24-business hour cancellation policy for new patient and consultation appointments. Failure to comply with the cancellation policy may result in additional charges. A $25 fee will be applied to all NSF checks. By signing below, I agree to the financial policy described above and will adhere to all its practices.

Signature of Patient or Legal Representative	Patient Name (Printed)	Date Signed

Please Describe Your Reason(s) for This Visit in Order of Importance:

1.	Date of Onset:	How much of the time do you feel pain? ☐0-25% ☐ 26-50% ☐51-75% ☐76-100%
Please mark how your condition happened: ☐ Illness ☐ Injury ☐ Auto Accident ☐ Developed over time ☐ Other:		Using a scale in which "0" is no pain and "10" is severe, the number that best reflects your condition. 0 1 2 3 4 5 6 7 8 9 10
List anything that makes your condition better:	List anything that makes your condition worse:	

2.	Date of Onset:	How much of the time do you feel pain? ☐0-25% ☐ 26-50% ☐51-75% ☐76-100%
Please mark how your condition happened: ☐ Illness ☐ Injury ☐ Auto Accident ☐ Developed over time ☐ Other:		Using a scale in which "0" is no pain and "10" is severe, the number that best reflects your condition. 0 1 2 3 4 5 6 7 8 9 10
List anything that makes your condition better:	List anything that makes your condition worse:	



Please mark areas of discomfort/pain on the figures above using the symbol that best describes the feeling:

A Aches
B Burning
N Numbness
O Other Symptoms
+++ Sharp or Stabbing
ooo Pins and Needles
➔ Radiates

Please check the box that best describes whether your pain or symptom(s) limit normal activities:	**Normal**	**Somewhat Limited**	**Severely Limited**
ACTIVITY:			
Lifting			
Bending			
Standing			
Walking			
Sitting			
Climbing Stairs			
Running			
Resting in Bed/Sleeping			
Intercourse			
Computer Work/Typing			
Normal Work			
Household Activities			
Recreational Activities			
Other			

Have you seen other doctors for this condition? ☐ Yes ☐ No
If Yes, Explain:

Have you had X-ray or MRI studies for this condition? ☐ Yes ☐ No

Chiropractic Experience

Have you ever received Chiropractic care? ☐ Yes ☐ No

If yes, when?	Name of most recent Chiropractor:

Personal Incident History		*Briefly Explain:*
Broken Bones?	☐ Yes ☐ No	
Been in an Auto Accident?	☐ Yes ☐ No	
Had Major Sprains/Strains?	☐ Yes ☐ No	
Been Struck Unconscious?	☐ Yes ☐ No	
Had a Stroke?	☐ Yes ☐ No	

Medical Health History

List any medical problems that other doctors have diagnosed:

Surgeries:

Year	Reason

Other hospitalizations or Life Changing Events:

Year	Description

List your prescribed drugs and over-the-counter drugs:

Name the Drug	Strength	Frequency Taken	Reason

Any known allergies to medications?

SOCIAL AND OCCUPATIONAL HISTORY				
Job Description Including Physical Work Duties:				
Work Schedule:				
Recreational activities:				
Exercise	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never
Alcohol	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never
Tobacco	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never
Caffeine Drinks & Products	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never
Drugs	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never
Soft Drinks	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never
Water	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never

FAMILY HEALTH HISTORY			
Significant Health Problems		Significant Health Problems	
Father		Child	☐ M ☐
Mother		Child	☐ M ☐ F
Sibling	☐ M ☐ F	Child	☐ M ☐ F
Sibling	☐ M ☐ F	Child	☐ M ☐ F
Sibling	☐ M ☐ F	*Grandmother* *Maternal*	
Sibling	☐ M ☐ F	Grandfather *Maternal*	
Sibling	☐ M ☐ F	Grandmother *Paternal*	
Sibling	☐ M ☐ F	Grandfather *Paternal*	

For Women Only **Complete only if you (or the patient is) a woman over 16 years old**	
Are you pregnant?	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No
Experience painful periods?	☐ Yes ☐ No
Have irregular cycles?	☐ Yes ☐ No
Breast implants?	☐ Yes ☐ No
Taking birth control?	☐ Yes ☐ No

Review of Systems Please select all that you have had or currently have		
Lung Related Issues		
☐ COPD / Emphysema	☐ Asthma	☐ Other:
Cardiovascular Issues		
☐ Bypass surgery	☐ Pacemaker	☐ Irregular heartbeat
☐ Hypertension	☐ Coronary artery disease	☐ Hypercholesterolemia
☐ Myocardial Infarction	☐ Murmurs or Valve Disease	☐ Other:
Neurological Issues		
☐ Vision changes/loss	☐ One-sided Weakness	☐ Seizures
☐ Memory Loss	☐ Headaches	☐ Epilepsy
☐ Vertigo	☐ Loss of Smell	☐ Tremors
☐ Strokes/ TIAs	☐ Other:	
Endocrine/Hormonal Issues		
☐ Thyroid disease	☐ Diabetes If so, what type? ☐ Type I ☐ Type II ☐ Juvenile	
☐ Hormone Replacement therapy		☐ Other
Stomach Related Issues		
☐ Nausea	☐ Difficulty Swallowing	☐ Irritable Bowel/Colitis
☐ Frequent Abdominal Pain	☐ Hiatal Hernia	☐ Constipation
☐ Pancreatic disease	☐ Liver Disease	☐ Ulcers
☐ Bloody/ black tarry stools	☐ Bowel Incontinence	☐ Reflux/Heartburn
☐ Other		
Blood Related Issues		
☐ Anemia	☐ HIV positive	☐ Abnormal bleeding/bruising
☐ Sickle-cell anemia	☐ Enlarged lymph nodes	☐ Hemophilia
☐ Blood Clots	☐ Varicose veins	☐ Anticoagulant therapy
☐ Regular Aspirin Use	☐ Regular anti-inflammatory use (Motrin/Ibuprofen/Aleve, etc.)	
☐ Other:		
Skin Related Issues		
☐ Significant burns	☐ Significant rashes	☐ Skin grafts
☐ Psoriasis	☐ Other	
Bone/Muscle Related Issues		
☐ Rheumatoid arthritis	☐ Osteoarthritis	☐ Gout
☐ Broken bones	☐ Spinal fracture	☐ Spinal surgery
☐ Scoliosis	☐ Metal implants	☐ Joint surgery
☐ Other		
Psychological Issues		
☐ Depression	☐ Diagnosed emotional/mental disorders	
☐ Other		

Is there anything else in your past medical history that you feel is important to your care here?

Overall Health Status Questionnaire (Rand 36)

1. In general, would you say your health is ☐ Excellent-1 ☐ Very Good-2 ☐ Good-3 ☐ Fair-4 ☐ Poor-5

2. Compared to one year ago, how would you rate your health in general now?

Much better now than one year ago 1 ☐
Somewhat better now than one year ago 2 ☐
About the same 3 ☐
Somewhat worse now than one year ago 4 ☐
Much worse now than one year ago 5 ☐

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

(Check one number on each line)	Yes, Limited a lot	Yes, Limited a little	No, Not limited at all
3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.	1 ☐	2 ☐	3 ☐
4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	1 ☐	2 ☐	3 ☐
5. Lifting or carrying groceries.	1 ☐	2 ☐	3 ☐
6. Climbing several flights of stairs.	1 ☐	2 ☐	3 ☐
7. Climbing one flight of stairs.	1 ☐	2 ☐	3 ☐
8. Bending, kneeling, or stooping.	1 ☐	2 ☐	3 ☐
9. Walking more than a mile.	1 ☐	2 ☐	3 ☐
10. Walking several blocks.	1 ☐	2 ☐	3 ☐
11. Walking one block.	1 ☐	2 ☐	3 ☐
12. Bathing or dressing yourself.	1 ☐	2 ☐	3 ☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

(Check one number on each line)	Yes	No
13. Cut down the amount of time you spent on work or other activities.	1 ☐	2 ☐
14. Accomplished less than you would like.	1 ☐	2 ☐
15. Were limited in the kind of work or other activities.	1 ☐	2 ☐
16. Had difficulty performing the work or other activities. (for example, it took extra effort)	1 ☐	2 ☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

(Check one number)	Yes	No
17. Cut down the amount of time you spent on work or other activities.	1 ☐	2 ☐
18. Accomplished less than you would like.	1 ☐	2 ☐
19. Didn't do work or other activities as carefully as usual.	1 ☐	2 ☐

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? *(Check one number)*

☐1 Not at all ☐2 Slightly ☐3 Moderately ☐4 Quite a bit ☐5 Extremely

21. How much bodily pain have you had during the past 4 weeks?

☐1 None ☐2 Very mild ☐3 Mild ☐4 Moderate ☐5 Severe ☐6 Very Severe

22. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? *(Check one number)*

☐1 None at all ☐2 A little bit ☐3 Moderately ☐4 Quite a bit ☐5 Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer the comes closest to the way you have been feeling. (*Check one number on each line.)*

	How much of the time during the past 4 weeks…					
	All	Most	A good bit	Some	A little	None
23. Did you feel full of pep?	☐1	☐2	☐3	☐4	☐5	☐6
24. Have you been a very nervous person?	☐1	☐2	☐3	☐4	☐5	☐6
25. Have you felt so down in the dumps that nothing could cheer you up?	☐1	☐2	☐3	☐4	☐5	☐6
26. Have you felt calm and peaceful?	☐1	☐2	☐3	☐4	☐5	☐6
27. Did you have a lot of energy?	☐1	☐2	☐3	☐4	☐5	☐6
28. Have you felt downhearted and blue?	☐1	☐2	☐3	☐4	☐5	☐6
29. Did you feel worn out?	☐1	☐2	☐3	☐4	☐5	☐6
30. Have you been a happy person?	☐1	☐2	☐3	☐4	☐5	☐6
31. Did you feel tired?	☐1	☐2	☐3	☐4	☐5	☐6
32. During the past 4 weeks, how much of the time has your physical health or emotional health problems interfered with your social activities? (like visiting with friends, relatives, etc.)	☐1	☐2	☐3	☐4	☐5	☐6

How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a little easier than other people.	☐1	☐2	☐3	☐4	☐5
34. I am as healthy as anybody I know.	☐1	☐2	☐3	☐4	☐5
35. I expect my health to get worse.	☐1	☐2	☐3	☐4	☐5
36. My health is excellent.	☐1	☐2	☐3	☐4	☐5

Informed Consent for Chiropractic Care

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic care or management of my condition(s), on me (or on the patient named below, for whom I am legally responsible).

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

I understand and am informed that, though infrequent, as with any health procedure, there are certain complications which may arise during chiropractic health care. These complications include, but are not limited to, soreness, fractures, disc injuries, strokes, dislocations, and sprains. These complications are extremely rare. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

Neither the practice of chiropractic nor medicine is an exact science, but relies upon information related to the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases. There has been no promise, implied or otherwise, of a cure for any symptom, disease, or condition as a result of care in this office.

I understand that there are other forms of treatment, including drugs and surgery, which could be treatment options for my condition, but at this time, I choose chiropractic care.

Patient Name (printed) (or Legal Representative)	Signature of Patient (Or Legal Representative	Date Signed

Pregnancy Release (Women Only):
This is to certify that to the best of my knowledge I am not pregnant and the above office, doctors and/or staff have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Signature of Patient or Legal Representative	Date Signed

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment, or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that is related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
Healthcare Operations: We may disclose, as needed, your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund-raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____	_____	_____
Signature of Patient or Legal Representative	Patient Name (printed)	Date Signed