Mashike Chiropractic Family Wellness Center
APPLICATION FOR HEALTH CARE

Date of Application________________ Case # ______________________

Chiropractic Care is a system of Natural Health Care that uses the powerful healing ability of your body, allowing you to regain your health. Only by correcting the CAUSE of your condition can that condition be permanently corrected.

There are 3 conditions which must be met in order to accept your case;

1. That we are able to determine the CAUSE of your condition.
2. That we are reasonably sure we can produce favorable results.
3. That you will attend periodic workshops concerning your condition and how you can help yourself accelerate the healing process.

We will inquire as to your insurance benefits and notify you as soon as we obtain any information. You must also check to verify the same coverage.

Name ______________________ Birthdate______________________ Age __________

Address ______________________ City ______________________ State __________

Zip code ____________ Home Phone ______________________ Cell Phone ______________________

Male/ Female __________ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Name of Spouse ______________ Children & Ages ______________________

S.S. Number ______________ Drivers License Number ______________________

Employer ______________________ Phone Number ______________________

Occupation ______________________ Health Insurance ______________________

Primary Insured Name______________ Birthdate ______ Insured S.S. Number ______________

Insured Employer ______________________ Referred by ______________________

Please indicate if you are here because of ☐ Work Injury ☐ Auto Accident ☐ Date of Injury

The following questions are important to your care.

Current Health Complaint/ Reason for consulting our office: ______________________

____

Has this occurred before ? ☐ Yes ☐ No

When was the very first time that this occurred, even if it may have been minor or for only a short period of time: __________

What caused this condition? ______________________

Have you seen a Chiropractor before? ☐ Yes ☐ No Name of Chiropractor ______________________

Last visit date: ______________ For what condition? ______________________

Have you had treatment for THIS condition? ☐ Yes ☐ No When? __________ Results ______________

Name of Doctor seen ______________ Diagnosis ______________________

Are you now under the care for any condition? ☐ Yes ☐ No Explain ______________________

Have you had any Fractures?__________ Spinal Tap? __________ Operations?__________ If Yes, Please explain __________

____

Medical History

Have you been treated for any conditions in the last year? ○ No ○ Yes

If yes, please describe

Date of last physical exam Is there a chance that you are pregnant? ○ No ○ Yes

Have you had X-rays taken? ○ No ○ Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)!

What vitamins, minerals, or herbs do you currently take? (Please list for what conditions, dosage, and frequency).

Have you ever:	No	Yes	Briefly Explain
Broken bones?	○	○	
Been hospitalized?	○	○	
Been in an auto accident?	○	○	
Had Sprains/Strains?	○	○	
Been struck unconscious?	○	○	
Had surgery?	○	○	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

	No	Yes
Do you experience pain every day?	○	○
Do your symptoms interfere with daily life?	○	○
Does pain wake you up at night?	○	○
Are your symptoms worse during certain times of the day?	○	○
Do changes in weather affect your symptoms?	○	○
Do you wear orthotics?	○	○
Do you take vitamin supplements?	○	○

What activities aggravate your symptoms?

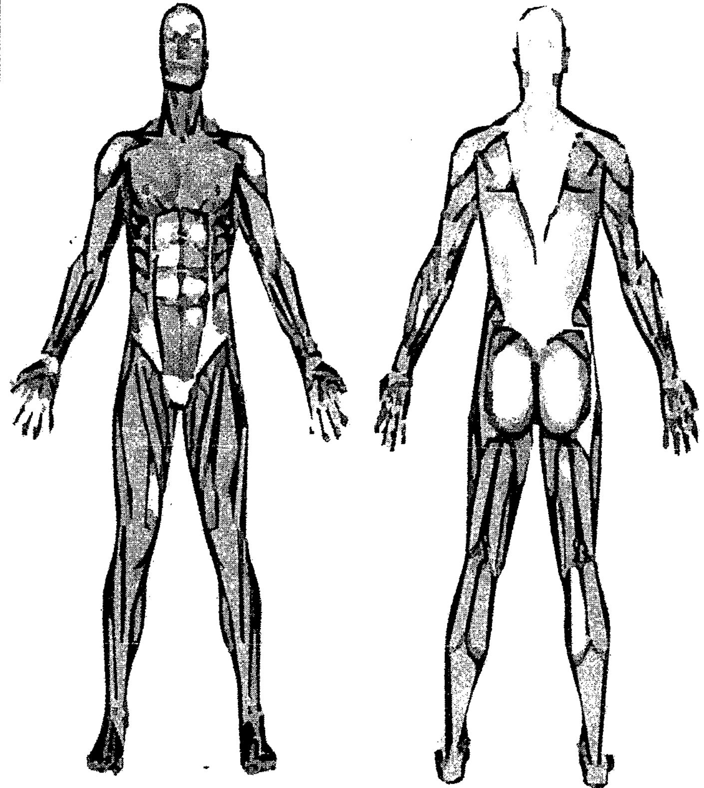
Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Coffee	○	○	○	○
Tobacco	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweeteners	○	○	○	○

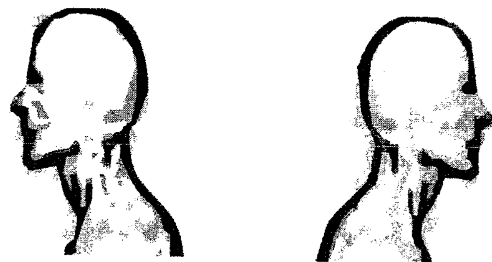
Have you ever suffered from:

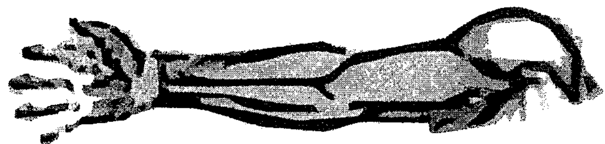
- [ ] Alcoholism
- [ ] Allergies
- [ ] Anemia
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Back Pain
- [ ] Breast Lump
- [ ] Bronchitis
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chest Pain/Conditions
- [ ] Cold Extremities
- [ ] Constipation
- [ ] Cramps
- [ ] Depression
- [ ] Diabetes
- [ ] Digestion Problems
- [ ] Dizziness
- [ ] Ears Ring
- [ ] Excessive Menstruation
- [ ] Eye Pain or Difficulties
- [ ] Fatigue
- [ ] Frequent Urination
- [ ] Headache
- [ ] Hemorrhoids
- [ ] High Blood Pressure
- [ ] Hot Flashes
- [ ] Irregular Heart Beat
- [ ] Irregular Cycle
- [ ] Kidney Infection
- [ ] Kidney Stones
- [ ] Loss of memory
- [ ] Loss of balance
- [ ] Loss of smell
- [ ] Loss of taste
- [ ] Lumps In Breast
- [ ] Neck Pain or Stiffness
- [ ] Nervousness
- [ ] Nosebleeds
- [ ] Pacemaker
- [ ] Polio
- [ ] Poor Posture
- [ ] Prostate Trouble
- [ ] Sciatica
- [ ] Shortness of breath
- [ ] Sinus Infection
- [ ] Sleep problems or Insomnia
- [ ] Spinal Curvatures
- [ ] Stroke
- [ ] Swelling of ankles
- [ ] Swollen Joints
- [ ] Thyroid Condition
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Varicose Veins
- [ ] Venereal Disease
- [ ] Other: ______

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing







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AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize Dr. Mashike to disclose to my Insurance Company or lawyer and all necessary information, which he may have acquired by examination or other means of my physical or mental condition, and I release him of any consequences thereof.

ASSIGNMENT OF PAYMENT

My attorney and or Insurance Company are hereby requested and authorized to pay direct to Dr. Mashike any moneys due him on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Dr. Mashike the difference between the total amount of his charges and the amount paid by the attorney and or the Insurance Company. It is further understood that I. the undersigned, agree to pay Dr. Mashike, the full amount of his charges, should my condition be such that is not covered by my policy or if for any reason the insurance company refuses to pay the full amount of my claim.

X-RAYS

Under the laws of the State of Michigan, x-rays are the property of this office. The amount paid by you or the Insurance company are for interpretation and x-rays will remain the property of this office. X-rays are not loaned, however we will have copies made which can be purchased for $35.00.

Signature of Applicant (or Agent) ______________________________

Relation to Patient if signed by Agent ______________________________

Date ______________________________