



**RAUCH CHIROPRACTIC**  
LIFE CENTER

**Patient Introduction**

38904 DEQUINDRE • STERLING HEIGHTS, MI 48310 • PHONE (586) 978-8240

Date: \_\_\_\_\_

**TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU PLEASE COMPLETE ALL QUESTIONS**

1. Name (last name first)		2. Date of birth	3. Age	4. Email address
5. Address		City	State	Zip
6. Telephone number				
7 <input type="checkbox"/> Married <input type="checkbox"/> Single	8. Name of spouse		9. Health	
10. No. of children	11. Names of children		12. Health	
13. Occupation		14. Employer		15. Work phone no.
16. Where do you feel the problem? Briefly describe complaint.				
17. Referred by		18. Have you had chiropractic care before? <input type="checkbox"/> Yes Where? <input type="checkbox"/> No		19. Do you have health insurance? <input type="checkbox"/> Yes Company: <input type="checkbox"/> No
20. Is it possible you are pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		21. Are you on Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	22. Are you on Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	23. Are you on a reimbursing insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No Company name:
24. Please indicate if you are here for care because of: <input type="checkbox"/> an on the job injury <input type="checkbox"/> an auto accident				
Date injured	Insurance company	Physician Name	Physician Address	
25. Have you ever had any falls, accidents or injuries? <input type="checkbox"/> Yes Please describe. Use <input type="checkbox"/> No other side if necessary.		MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY
26. Have you ever had surgery? <input type="checkbox"/> Yes Please explain. Use <input type="checkbox"/> No other side if necessary.		MONTH, YEAR	TYPE OF SURGERY	WHY WAS SURGERY PERFORMED?
27. Are you presently taking medication? <input type="checkbox"/> Yes Please list the name of <input type="checkbox"/> No the drug and tell why you are taking it. Use other side if necessary.		NAME OF DRUG	DOSES PER DAY	WHAT ARE YOU TAKING IT FOR?

28. Please check any of the following that give you difficulty.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Low blood pressure         | <input type="checkbox"/> Shooting head pains           | <input type="checkbox"/> Pain in shoulders and arms |
| <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Loss of smell                 | <input type="checkbox"/> Cold hands                 |
| <input type="checkbox"/> Sinus trouble              | <input type="checkbox"/> Hayfever                      | <input type="checkbox"/> Cold feet                  |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Loss of taste                 | <input type="checkbox"/> Anemia                     |
| <input type="checkbox"/> Thyroid trouble            | <input type="checkbox"/> Tightness of throat           | <input type="checkbox"/> Rheumatic fever            |
| <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Inflammation of throat        | <input type="checkbox"/> Nervous stomach            |
| <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Face flushed                  | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Loss of balance            | <input type="checkbox"/> Twitching of face             | <input type="checkbox"/> Inner tension              |
| <input type="checkbox"/> Muscle spasms in neck      | <input type="checkbox"/> Loss of memory                | <input type="checkbox"/> Irritability               |
| <input type="checkbox"/> Chest pains                | <input type="checkbox"/> Fatigue                       | <input type="checkbox"/> Cold sweats                |
| <input type="checkbox"/> Shortness of breath        | <input type="checkbox"/> Depression                    | <input type="checkbox"/> Indigestion                |
| <input type="checkbox"/> Heart pain                 | <input type="checkbox"/> Head feels too heavy          | <input type="checkbox"/> Intestinal gas             |
| <input type="checkbox"/> Mid-back pain              | <input type="checkbox"/> Ringing in ears               | <input type="checkbox"/> Menstrual cramps and pain  |
| <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Wear glasses                  | <input type="checkbox"/> Menstrual irregularity     |
| <input type="checkbox"/> Stomach trouble            | <input type="checkbox"/> Lights bother eyes            | <input type="checkbox"/> Painful joints             |
| <input type="checkbox"/> Nerves and nervousness     | <input type="checkbox"/> Grating in neck               | <input type="checkbox"/> Swollen joints             |
| <input type="checkbox"/> Gall bladder trouble       | <input type="checkbox"/> Tightness of shoulder muscles | <input type="checkbox"/> Swollen ankles             |
| <input type="checkbox"/> Low back pain              |  |   |
| <input type="checkbox"/> Constipation               |  |   |
| <input type="checkbox"/> Kidney trouble             |  |   |
| <input type="checkbox"/> Diabetes                   |  |   |
| <input type="checkbox"/> Cancer                     |  |   |
| <input type="checkbox"/> Sleeping problems          |  |   |
| <input type="checkbox"/> Arthritis                  |  |   |
| <input type="checkbox"/> Numbness in legs           |  |   |
| <input type="checkbox"/> Pains in legs and feet     |  |   |
| <input type="checkbox"/> Neck pain                  |  |   |
| <input type="checkbox"/> T. B.                      |  |   |
| <input type="checkbox"/> Heart palpitation          |  |   |
| <input type="checkbox"/> Heart attacks              |  |   |
| <input type="checkbox"/> Liver trouble              |  |   |
| <input type="checkbox"/> Slipped disc               |  |   |
| <input type="checkbox"/> Numbness in arms and hands |  |   |

Use this space for additional comments if necessary

DO NOT WRITE BELOW THIS LINE

Doctor's Use Only

COMMENTS

SPINAL ANALYSIS

At \_\_\_\_\_ 1L \_\_\_\_\_  
 Ax \_\_\_\_\_ 2 \_\_\_\_\_  
 3C \_\_\_\_\_ 3 \_\_\_\_\_  
 4 \_\_\_\_\_ 4 \_\_\_\_\_  
 5 \_\_\_\_\_ 5 \_\_\_\_\_  
 6 \_\_\_\_\_  
 7 \_\_\_\_\_  
 1D \_\_\_\_\_ R. Ilium \_\_\_\_\_  
 2 \_\_\_\_\_  
 3 \_\_\_\_\_  
 4 \_\_\_\_\_  
 5 \_\_\_\_\_ L. Ilium \_\_\_\_\_  
 6 \_\_\_\_\_  
 7 \_\_\_\_\_  
 8 \_\_\_\_\_  
 9 \_\_\_\_\_ C.S. \_\_\_\_\_  
 10 \_\_\_\_\_ L.S. \_\_\_\_\_  
 11 \_\_\_\_\_  
 12 \_\_\_\_\_  
 Re-evaluation \_\_\_\_\_ days

Work restriction  Yes  No \_\_\_\_\_  
 Cervical support  Yes  No \_\_\_\_\_  
 Lumbar support  Yes  No \_\_\_\_\_

Work excuse  Yes  No \_\_\_\_\_  
 EKG  Yes  No \_\_\_\_\_  
 Extended care  Yes  No \_\_\_\_\_

Height \_\_\_\_\_ B.P. \_\_\_\_\_  
 Weight \_\_\_\_\_ Pulse \_\_\_\_\_  
 Temp. \_\_\_\_\_ Resp. \_\_\_\_\_

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Bragard test        | <input type="checkbox"/> Cerv. lateral flexion (l) | <input type="checkbox"/> DI. extension           |
| <input type="checkbox"/> Lasegue test        | <input type="checkbox"/> Cerv. lateral flexion (r) | <input type="checkbox"/> DI. lateral flexion (l) |
| <input type="checkbox"/> Low. extended extr. | <input type="checkbox"/> Cerv. rotation (l)        | <input type="checkbox"/> DI. lateral flexion (r) |
| <input type="checkbox"/> Cervical flexion    | <input type="checkbox"/> Cerv. rotation (r)        | <input type="checkbox"/> DI. rotation (l)        |
| <input type="checkbox"/> Cervical extension  | <input type="checkbox"/> Dorsolumbar flexion       | <input type="checkbox"/> DI. rotation (r)        |