Oakland Chiropractic Clinic, PLC

Dr. Gary Sclabassi

39680 W. 14 Mile Rd.
Walled Lake, MI 48390
Phone: (248) 960-8828
Fax: (248) 960-8829

www.OaklandChiropracticClinic.com

Date: / /

PATIENT INFORMATION	*INSURANCE INFORMATION*
Name:	Are you covered by insurance? ☐ Yes ☐ No
Address:	Insurance Company:
	Subscriber Name:
Sex: ☐M ☐F Age: Date of Birth: / /	Relationship to patient: *(check below)*
☐single ☐married ☐widowed ☐separated ☐divorced ☐partnered	☐ self ☐ spouse ☐ parent/guardian ☐ other
Patient Social Security #:	**Assignment & Release:**
Occupation:	I certify that I have insurance coverage and assign directly to Oakland Chiropractic Clinic, PLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.
Employer:	
Employer phone:	
Employer Address:	
Who may we thank for referring you?	Signature:

CONTACT INFORMATION

Home Phone:	***EMERGENCY CONTACT:***
Work Phone:	Relationship:
Cell Phone:	Home Phone:
Preferred contact: ☐ Home ☐ Work ☐ Cell	Work Phone:
E-mail:	Cell Phone:

Reason for visit:	
When did it start?	How did it start?
Is your condition due to an accident? ☐ No ☐ Yes (if so, what type) ☐ Work-related ☐ Vehicle ☐ Other:	
Rate your symptoms (0-10):	Please describe your condition:
Is your condition getting worse: ☐ No ☐ Yes	Is it constant or does it come and go? ☐ constant ☐ comes & goes ☐ don't know
Does it interfere with your ☐ work ☐ sleep ☐ daily activities ☐ sports/recreation ☐ other:	
Do you experience pain with: ☐ standing ☐ walking ☐ sitting ☐ bending ☐ lying down ☐ lifting ☐ sports ☐self-care	
What treatments have you already had for this condition ☐ medical ☐ physical therapy ☐ surgical ☐ x-ray/MRI ☐ other ☐ none	
With whom?	

Oakland Chiropractic Clinic, PLC

Health History- *(Please read the list and check any items that apply to you)*

Previously Diagnosed or Current Conditions		
□ AIDS/HIV	□ Hepatitis	□ Stroke
□ Anemia	□ Herniated disc / degenerated disc	□ Thyroid problems
□ Arthritis	□ High blood cholesterol	□ Tumors
□ Bleeding disorders	□ High blood pressure	Others: *(please list)*
□ Cancer	□ Multiple sclerosis	
□ Chemical dependency	□ Osteoporosis / Osteopenia	
□ Depression/Anxiety	□ Pinched nerve	
□ Diabetes	□ Polio	
□ Epilepsy/Seizures	□ Prostate problems	
□ Headaches	□ Rheumatoid arthritis	
Height: feet inches	Weight: pounds	
Please list any prior surgeries or significant injuries *(include date)*		

Family History *(Does anyone in your family have any of the following)*

□ Autoimmune disorders	□ Diabetes	□ Kidney disease
□ Arthritis	□ Heart disease	□ Osteoporosis
□ Cancer	□ Mental Illness	□ Seizure disorders

MEDICATIONS	ALLERGIES	VITAMINS/SUPPLEMENTS/HERBS

Social History

My work duties include: □ Standing □ Sitting □ Light labor □ Heavy Labor □ Other

My exercise level is: □ Intense □ Moderate □ Light □ Minimal *List Activities:*

My habits include: □ Smoking/Tobacco use _____packs/day □ Alcohol consumption _____drinks/week

□ Caffeine (coffee, soda, tea) _____cups/day □ High stress level:

Primary Care Provider:

Name: Please send report to my Dr. Yes No

_____ _____

Patient signature Date

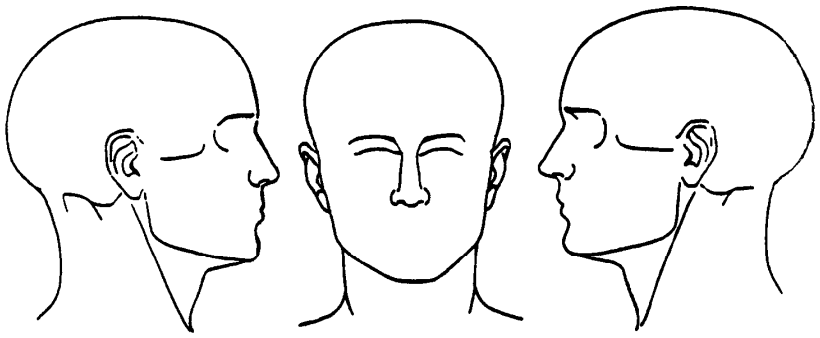
Patient Name:_____
(please print)

Date:_____

Oakland
Chiropractic
Clinic, PLC
www.OaklandChiropracticClinic.com

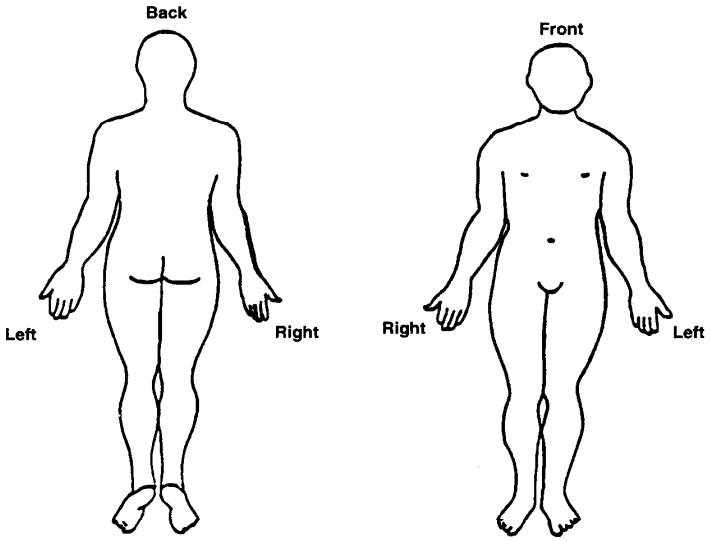
Please draw the location of your symptoms on the body diagram below and mark your current level of pain on the line at the bottom of the diagram.

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
^ ^ ^ ^ ^ ^	= = = = = =	o o o o o o	. . . . .	/ / / / / / /	x x x x x
^ ^ ^ ^	= = = = = =	o o o o	. . . . .	/ / / /	x x x



No Pain ——— Worst Pain Possible

Please make a slash through this line as to the level of your pain.



No Pain ——— Worst Pain Possible

Please make a slash through this line as to the level of your pain.

Patient Signature:_____ **Date:**_____