BUTZIN CHIROPRACTIC CLINICS, L.L.C.

2050 Chesley Dr., Suite 2 Sterling Heights, MI 48310

PATIENT INTRODUCTION FORM

Date____________________ Social Security Number ________________________

Name ____ Phone No. (Home) ___________ (Work) ______________
(last) (first) (M)

Address____ Date of Birth________________Marital Status___________

City____ Name of Spouse, Children ________________________

State________________ Zip ____________________ Occupation / Profession ________________________

Email____ Employer _________________________________

Allergies ____ Medications _________________________________

Smoker? _____________________ Frequency?___________________________________

Briefly describe complaints ____

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Are these complaints related to: ☐ Auto Accident? ☐ Work Injury? ☐ None ☐ Other _______________________

Referred By: ____

Have you had previous chiropractic care? ☐ Yes ☐ No Where? ____

Do you have health insurance? ☐ Yes ☐ No Name of company? __________________________________

DO YOU HAVE DIFFICULTY WITH THE FOLLOWING? IF YES MARK (/)

☐ Dizziness	☐ Asthma	☐ Bladder Control	☐ Arthritis
☐ Fainting	☐ Chest Pains	☐ Constipation	☐ Cancer Type-__________
☐ Grating in Neck	☐ Digestive Problems	☐ Disc Problems	☐ Carpel Tunnel
☐ Hay Fever/Allergies	☐ Heart Attacks	☐ Gall Bladder Disease	☐ Cold Feet
☐ Headaches	☐ Heartburn	☐ Knee Pain	☐ Cold Hands
☐ Head Feels to Heavy	☐ Indigestion	☐ Kidney Disease	☐ Cold Sweats
☐ Lights Bother Eyes	☐ Mid Back Pain	☐ Liver Disease	☐ Depression
☐ Loss of Balance	☐ Nausea	☐ Low Back Pain	☐ Diabetes
☐ Loss of Smell	☐ Nervous Stomach	☐ Menstrual Cramps/Pain	☐ Fatigue
☐ Muscle Spasm in Neck	☐ Numbness in Arms	☐ Numbness in Feet	☐ High Blood Pressure
☐ Neck Pain	☐ Numbness in Hands	☐ Numbness in Legs	☐ Irritability
☐ Ringing in Ears	☐ Shortness of Breath	☐ Pain in Legs/Feet	☐ Lack of Energy
☐ Shooting Head Pains	☐ Shoulder Pain/Tightness	☐ Pinched Nerves	☐ Low Blood Pressure
☐ Sinus Trouble	☐ Tingling in Arms	☐ Tingling in Feet	☐ Painful Joints
☐ Wear Glasses	☐ Tingling in Hands	☐ Tingling in Legs	☐ Sleeping Problems

PATIENT AGREEMENT ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Butzin, Matoshko Chiropractic Clinics, P.L.L.C. all medical 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 hereby authorize this clinic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

____ ______________________________
Signature of Insured/Guardian Date