UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Oster Chiropractic Clinic
Dr. Catherine J. Oster-Kostuch
27101 Harper Ave.
St. Clair Shores, MI 48081
(586) 772-3040
fax (586) 772-3074

Today's Date (MM/DD/YYYY)

Patient Number (office use only)

Age

Gender
◯ Male ◯ Female

Race
◯ American Indian ◯ Alaskan Native ◯ Asian ◯ Black or African American
◯ Native Hawaiian ◯ Other Pacific Islander ◯ Other ◯ White
◯ Decline to answer

Ethnicity
◯ Hispanic or Latino
◯ Not Hispanic or Latino
◯ Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Smoking Status (age 13 and over)
◯ Never A Smoker ◯ Former Smoker
◯ Current Every Day Smoker ◯ Current Some Day Smoker
◯ Heavy Smoker ◯ Light Smoker

Address

Marital Status ◯ Married
◯ Single ◯ Divorced
◯ Widowed ◯ Separated

City | **State/Province** | **ZIP/Postal Code**

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?
◯ Yes ◯ No

City | **State/Province** | **ZIP/Postal Code**

Preferred method of contact?
◯ Home Phone ◯ Cell Phone
◯ Work Phone ◯ Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?
◯ Self ◯ Spouse ◯ Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City | **State/Province** | **ZIP/Postal Code** | **Employer's Phone**

I certify that any changes to my personal information have been updated above for your records. _____
Signature

UPDATED CONTACT INFORMATION

UPDATED PATIENT HISTORY

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◯ **I have new contact information**

Today's Date (MM/DD/YYYY) _____

Patient Number (office use only) _____

Your Last Name _____ **Your First Name** _____ **Your Middle Name (or Initial)** _____

Please select one:

◯ **Progress evaluation** – I've been under active care and this is a periodic reevaluation. ◯ **New condition** – I've been under care and a new or returning condition has emerged.

◯ **Maintenance patient** – I'm under maintenance care with a new or returning health issue. ◯ **Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

Please describe your Primary Complaint in the space below. Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint
The primary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other _____

Secondary Complaint
The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other _____

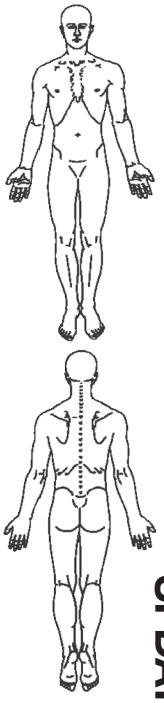
Additional Complaint
The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):
◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Acupuncture
◯ Over-the-counter drugs ◯ Chiropractic
◯ Homeopathic remedies ◯ Massage
◯ Physical therapy ◯ Ice
◯ Surgery ◯ Heat
◯ Other _____

Location
(Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



1. Review of systems (Identify any changes since your most recent evaluation with us):

	Worse	No Change	Improved
a. Musculoskeletal System – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	◯	◯	◯
b. Neurological System – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	◯	◯	◯
c. Cardiovascular System – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	◯	◯	◯
d. Respiratory System – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	◯	◯	◯
e. Digestive System – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	◯	◯	◯
f. Sensory System – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	◯	◯	◯
g. Skin System – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	◯	◯	◯
h. Endocrine System– Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	◯	◯	◯
i. Genitourinary System – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	◯	◯	◯
j. Constitutional System – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	◯	◯	◯

UPDATED PATIENT HISTORY

Doctor's Initials _____

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2. Illnesses, operations, injuries or treatments since your most recent evaluation with us: _____

_____

_____

3. Medications (please list all prescription and over-the-counter): _____

_____

_____

4. Social History (Tell Dr. Oster about your health habits and stress levels.)

Alcohol use	◯ Daily	◯ Weekly	How much?		Prayer or meditation?	◯ Yes	◯ No
Coffee use	◯ Daily	◯ Weekly	How much?		Job pressure/stress?	◯ Yes	◯ No
Tobacco use	◯ Daily	◯ Weekly	How much?		Financial peace?	◯ Yes	◯ No
Exercising	◯ Daily	◯ Weekly	How much?		Vaccinated?	◯ Yes	◯ No
Pain relievers	◯ Daily	◯ Weekly	How much?		Mercury fillings?	◯ Yes	◯ No
Soft drinks	◯ Daily	◯ Weekly	How much?		Recreational drugs?	◯ Yes	◯ No
Water intake	◯ Daily	◯ Weekly	How much?				

Hobbies: _____

5. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	◯	◯	◯	◯
Rising out of chair	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Lying down	◯	◯	◯	◯
Bending over	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯
Driving a car	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering or bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love life	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Exercising	◯	◯	◯	◯
Yard work	◯	◯	◯	◯

6. Is there anything else Dr. Oster should know about your current condition, your progress or ways your current condition is affecting your life?

_____

_____ _____

Patient (or Guardian's) signature Date (MM/DD/YYYY)

Patient name _____

Patient Number _____
(office use only)

Consultation Notes

Doctor's Initials _____

UPDATED PATIENT HISTORY