GANTOS
CHIROPRACTIC CENTER, P.C.

David J. Gantos, D.C.

6045 Corunna Rd., Ste A
Flint, MI 48532
(810) 706-0526

Patient Information Case # _____

General Information

Patient Last Name: _____ **First**: _____

Address: _____ **City**:_____

State: _____ **Zip**: _____ **Birthday**: ____/____/_____ **Gender**: F / M **Social Security**: _ _ _ /_ _ /_ _ _ _

Home Phone: _____ **Cell Phone**: _____

□ Married □ Single □ Widowed □ Divorced

Employment: □ Full Time □ Part Time □ Not Employed □ Retired
Employer's Name _____Occupation _____
EMPLOYED Address _____ City _____
State _____ Zip Code_____ Phone _____
Spouse's Name _____ Spouse's Date of Birth ___/____/_____
Spouse's Employer _____
Referred By: _____

Emergency Contact Name: _____ Relationship to Patient: _____
Phone Number: _____

Insurance

Release of Insurance use: Dr. David Gantos may use my health care and insurance information and may disclose such information to my Insurance Provider and their agents for the purpose of obtaining payment for services and determining insurance benefits.

Patient Name: _____ Date:_____

Signature: _____

Accident Information Is this condition due to an accident? □ Yes □ No
Type of accident: □ Auto □ Work □Home □Other _____
To whom have you made a report regarding this injury to? □ Auto Company □ Work Comp. □ Employer □ Other

Medications

Name	Dosage	How Often Taken	Taken for

Case # _____

Allergies

Are you allergic to anything? (Foods, Medication, Nature) □No □Yes

If Yes, Please list: _____

Patient Condition

Reason for Visit:_____

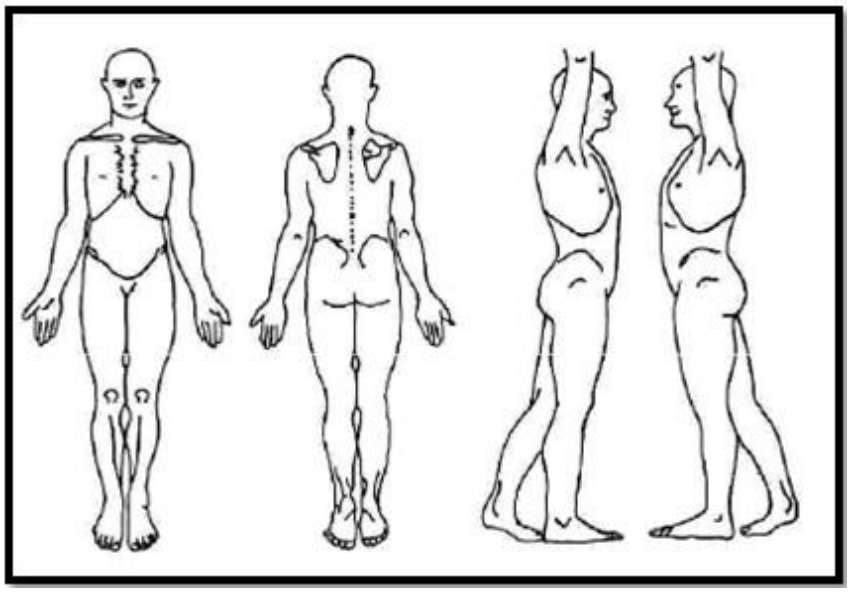
When did your symptoms start? _____

Is this condition getting progressively worse? □ Yes □ No

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) 1 2 3 4 5 6 7 8 9 10

Type of pain: □Sharp □Dull □Throbbing □Numbness □Aching □Shooting
□Burning □Tingling □Cramps □Stiffness □Swelling

*Mark the picture where you are having your pain:



How often are you having this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your □Work □Sleep □Daily Routine □Recreation

Activities or movements that are painful are □Sitting □Standing □Walking □Bending □Laying Down

Health History

What treatment have you already had for your condition? □Medical □Surgery □Physical Therapy
□Chiropractic Services □None □Other _____

Injuries/Surgeries you have had		Date
Falls	_____	_____
Head Injury	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgery	_____	_____

How many kids have you had? _____

Are you currently pregnant or could be? □No □Yes Due Date: _____

Case # _____

Exercise:	Work Activity:	Habits:	
□ None	□ Sitting	□ Smoking	Packs/Day _____
□ Moderate	□ Standing	□ Alcohol	Drinks/ Week _____
□ Daily	□ Light Labor	□ Coffee/ Caffeine Drinks	Cups/Day _____
□ Heavy	□ Heavy Labor	□ High Stress Level	Reason_____

Place a mark on "yes" or "no" to indicate if you have had any of the following

AIDS/HIV	□ Yes □ No	Heart Disease	□ Yes □ No	Rheumatoid Arthritis	□ Yes □ No
Alcoholism	□ Yes □ No	Hepatitis	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Allergy Shots	□ Yes □ No	Hernia	□ Yes □ No	Scarlet Fever	□ Yes □ No
Anemia	□ Yes □ No	Herniated Disk	□ Yes □ No	Stroke	□ Yes □ No
Anorexia	□ Yes □ No	Herpes	□ Yes □ No	Suicide Attempt	□ Yes □ No
Appendicitis	□ Yes □ No	High Cholesterol	□ Yes □ No	Thyroid Problems	□ Yes □ No
Arthritis	□ Yes □ No	Kidney Disease	□ Yes □ No	Tonsillitis	□ Yes □ No
Bleeding Disorders	□ Yes □ No	Liver Disease	□ Yes □ No	Tuberculosis	□ Yes □ No
Breast Lump	□ Yes □ No	Measles	□ Yes □ No	Tumor Growths	□ Yes □ No
Bronchitis	□ Yes □ No	Migraine Headaches	□ Yes □ No	Typhoid Fever	□ Yes □ No
Bulimia	□ Yes □ No	Miscarriage	□ Yes □ No	Ulcers	□ Yes □ No
Cancer	□ Yes □ No	Mononucleosis	□ Yes □ No	Vaginal Infections	□ Yes □ No
Cataracts	□ Yes □ No	Multiple Sclerosis	□ Yes □ No	Venereal Disease	□ Yes □ No
Chicken pox	□ Yes □ No	Osteoporosis	□ Yes □ No		
Diabetes	□ Yes □ No	Pacemaker	□ Yes □ No		
Emphysema	□ Yes □ No	Parkinson's Disease	□ Yes □ No		
Epilepsy	□ Yes □ No	Pinched Nerve	□ Yes □ No		
Fractures	□ Yes □ No	Pneumonia	□ Yes □ No		
Glaucoma	□ Yes □ No	Polio	□ Yes □ No		
Goiter	□ Yes □ No	Prostate Problem	□ Yes □ No		
Gonorrhea	□ Yes □ No	Prosthesis	□ Yes □ No		
Gout	□ Yes □ No	Psychiatric Care	□ Yes □ No		

OTHER_____