CONFIDENTIAL PATIENT INFORMATION

DATE______________________ PATIENT # _________________________

LAST NAME________________________________FIRST_______________________MI__________

ADDRESS_________________________________CITY STATE ZIP_____________________________

PRI. PHONE_________________CELL_________________EMAIL_____________________________

SEX: M F ETHNICITY: Hispanic Not Hispanic Declined to state MARITAL: S M D W

RACE: White Black: African American Asian Native Hawaiian American Indian Alaska Native Declined to state

BIRTHDATE: _____________SSN# _________________REFERRED BY:_______________________

EMPLOYER_________________________________PHONE #__________________EXT __________

SPOUSE________________________DOB____________ EMPLOYER _________________________

SMOKING STATUS: Never Former Current everyday Current some days (Please circle one)

MEDICATION: ____________________ ______________________ ________________________

Please provide the front desk with your list of current medications

MEDICATION ALLERGIES: _____________________ __________________ __________________

SURGERIES / APPROX DATE ____________________ __________________ __________________

PURPOSE OF THIS APPOINTMENT _______________________________onset date_____________

OTHER TESTS PERFORMED FOR THIS CONDITION _____________________________________

Which facility? ____________________________ Ordering doctor ____________________________

LIST SYMPTOMS YOU ARE EXPERIENCING TODAY AND NUMBER THE SEVERITY LEVEL

***** (1-10) (1) Very Mild (5) Moderate (10) Remarkably severe *****

Symptom	Severity level	Symptom	Severity level
__________________________	______	__________________________	_______
__________________________	______	__________________________	_______
__________________________	______	__________________________	_______
__________________________	______	__________________________	_______

DO YOU HAVE ANY CURRENT WORK RESTRICTIONS DUE TO THIS CONDITION? Y N

___________________________________What kind of work do you do? _______________________

(list restrictions)

NAME ______________________ (PAGE 2)

ARE YOUR PROBLEMS DUE TO AN INJURY? Y N DATE OF INJURY ___________

Job Related ________ Auto Accident ________Personal Injury _______ Other ___________________

***** If yours is an auto accident or work injury, please notify the front desk for additional form. *****

HAVE YOU SUFFERED FROM: Please circle (Current or Past)

GENERAL SYMPTOMS			GASTRO-INTESTINAL			EAR NOSE THROAT			RESPIRATORY		
Bronchitis	C	P	Belching / Gas	C	P	Asthma	C	P	Chest Pain	C	P
Chills	C	P	Colon Trouble	C	P	Deafness	C	P	Cough	C	P
Convulsion	C	P	Constipation	C	P	Earache	C	P	Diff Breathing	C	P
Dizziness	C	P	Diarrhea	C	P	Ear Discharge	C	P	Spitting Blood	C	P
Fainting	C	P	Gall Bladder	C	P	Ear Noises	C	P			
Fatigue	C	P	Hemorrhoids	C	P	Thyroid	C	P			
Headache	C	P	Jaundice	C	P	Frequent colds	C	P			
Sleep loss	C	P	Liver Problems	C	P	Hay Fever	C	P			
Weight Loss	C	P	Nausea	C	P	Sinusitis	C	P			
Nervousness	C	P	Stomach Pain	C	P	Nose Bleeds	C	P			
Night Sweats	C	P	Vomiting	C	P	Blurred Vision	C	P			
Wheezing	C	P	Heart Burn	C	P	Sore Throats	C	P			

BONE & JOINTS			CARDIO-VASCULAR			SKIN OR ALLERGIES			GENITO-URINARY		
Backache	C	P	High BP	C	P	Bruising	C	P	Bed Wetting	C	P
Foot Trouble	C	P	Low BP	C	P	Dryness	C	P	Blood in urine	C	P
Hernia	C	P	Chest Pain	C	P	Eczema	C	P	Freq Urination	C	P
Mid Back Pain	C	P	Heart Trouble	C	P	Hives	C	P	Kidney Infect.	C	P
Tail bone pain	C	P	Circulatory	C	P	Itching	C	P	Kidney Stones	C	P
Stiff Neck	C	P	Rapid Heart	C	P	Sensitivity	C	P	Prostate Problem	C	P
Sp Curvature	C	P	Slow Heart	C	P						
Swollen Joints	C	P	Stroke	C	P						
Tremors	C	P	Varicose veins	C	P						

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

Appendicitis	____	Anemia	_____	Heart Disease	_____	Arthritis	____	Pneumonia	____
Measles	____	Goiter	_____	Epilepsy	_____	Rheumatic Fever	____	Mumps	____
Mental Disorder	____	TB	_____	Polio	_____	Chicken Pox	____	Whooping Cough	____
Cancer	____	HIV Positive	_____	Diabetes	_____	Alcoholism	____	Pleurisy	____

FAMILY HISTORY:	Mother	Father	Siblings
Diabetes:	____	_____	_____
Cardiovascular:	____	_____	_____
Cancer:	____	_____	_____
Back Problems:	_____	_____	_____

ARE YOU COVERED BY INSURANCE? YES NO

******* IF YES, PLEASE GIVE THE FRONT DESK YOU INSURANCE CARD TO COPY *******

<u>PAYMENT IS EXPECTED AT TIME OF VISIT.</u>

NAME OF PERSON RESPONSIBLE FOR PAYMENT ______________________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that McMullen Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to McMullen Chiropractic Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENTS SIGNATURE____________________________________DATE______________________

(Parent or guardian if minor)