

CONFIDENTIAL PRACTICE MEMBER INFORMATION

Welcome. This information is important, please print.

Date _____

Name _____ SS# _____

Home Phone _____ Cell _____ Work _____

Address _____

City _____ State _____ Zip _____

Email _____ Birth date _____ Sex: M F Marital Status: S M W D

Occupation _____ Employer _____

Address _____

City _____ State _____ Zip _____

Children _____

Who referred you to the office? _____

Have you ever been to a chiropractor before? _____ If so, when? _____

Do you have any symptoms? If so, what are they and how have they affected your life?

Are you currently under any Doctors care? _____

Current medications? _____

If this is work related have you reported it to your employer? Yes No

Is this related to an auto accident? Yes No Date of accident? _____

Females: Are you pregnant? Yes _____ No _____ Not sure _____

If the Doctor determines that services are necessary, all charges are payable when rendered.

HISTORY

“Your body’s current condition is a result of your past history. Most people have experienced dozens of impacts that could cause a Vertebral Subluxation. I want to ask you about some of yours.”

AUTO

Tell me about your most recent auto accident. What happened? What treatment did you have?

WORK

“Most all of our patients have experienced some type of work-related accidents. Tell me about the most recent work-related injury. Keeping in mind that most any stress or strain to your body is serious enough to mention.”

What happened? _____

Any treatment? _____

OTHER

Have you ever broken any bones or had any concussions? _____

Have you had any surgery? _____

What repetitive activities do you perform at work or play? _____

Do/Have you experience(d) any emotional stress in your life?			Yes	No
Did/Do you smoke or use tobacco?	Always	Sometimes	Rarely	Never
Did/Do you drink alcohol?	Always	Sometimes	Rarely	Never
Did/Do you use illicit drugs?	Always	Sometimes	Rarely	Never
Did/Do you use over the counter drugs?	Always	Sometimes	Rarely	Never

PLEASE INDICATE ANY OF THE FOLLOWING THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR.

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Appetite Poor |
| <input type="checkbox"/> Appetite Excessive | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Blood Pressure-High | <input type="checkbox"/> Blood Pressure-Low |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Change in moles | <input type="checkbox"/> Change in skin color |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Ear discharge | <input type="checkbox"/> Ear infection | <input type="checkbox"/> Ears ringing |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Gas | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Heart irregularities | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Sinus | <input type="checkbox"/> Skin conditions | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Sweats |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Tiredness | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Weight loss |

Please briefly describe any chronic pain or problems:

Please indicate which of the following you have a history of in your family. Please go back as far as your grandparents if you can.

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stroke | | |

I understand and agree that health and accident insurance policies are an agreement between the carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I also understand if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I hereby authorize the doctor at McFadden Chiropractic Wellness Center, PC to administer any care as he deems necessary. I certify that the above information is true and correct.

Print Name _____ Signature (Guardian) _____

Terms of Acceptance

When an individual seeks chiropractic health care and we accept this individual for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. The goal is to eliminate subluxations within the spinal column, which interfere with the expression of the body's innate wisdom. It is important that you understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is gentle, specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, treatment for those findings, we will recommend that you seek the services of health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate major interference to the expression of the body's innate wisdom. Our method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print Name)

(Signature/Guardian)

Notice of Privacy Practices

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

(Signature/Guardian)