McNabb Chiropractic Clinic

Date_____

CONFIDENTIAL PATIENT INFORMATION

Drivers License # _____

Name_____ Soc. Sec. No._____ Home Phone_____

Address_____ City_____ Zip Code_____

Age_____ Birth Date_____ Marital: M S W D How many children?_____

Occupation_____ Employer_____

Address_____ Office Phone_____

Insured's name if patient is a dependent_____ Soc. Sec. No._____

Name of Insurance Company_____ Address_____

Name of Wife or Husband_____ Occupation_____

Employer_____ Address_____

Patient's nearest relative_____ Address_____ Phone_____

Referred by _____

Is condition due to injury or sickness arising out of patient's empoyment? ☐ Yes ☐ No

Date symptoms appeared or accident happened _____

Patient ever had same or similar condition? ☐ Yes ☐ No If yes, when and describe _____

_____

Have you lost any days from work? _____

Date of last physical examination_____ Female: Are you Pregnant_____

What operations have you had _____

Serious illnesses _____

Have you ever been under Chiropractic Care ☐ *Yes* ☐ *No* *Doctor's Name* _____

Have You Ever Suffered From:

- ☐ Allergy
- ☐ Dizziness
- ☐ Fatigue
- ☐ Headache
- ☐ Loss of sleep
- ☐ Ulcers
- ☐ Nervousness/Depression
- ☐ Numbness
- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot trouble
- ☐ Low back pain
- ☐ Neck pain or stiffness

Tingling or numbness in:

- ☐ Shoulders ☐ Hips
- ☐ Arms ☐ Legs
- ☐ Elbows ☐ Knees
- ☐ Hands ☐ Feet

- ☐ Poor posture
- ☐ Sciatica
- ☐ Spinal curvatures
- ☐ Swollen joints
- ☐ Colon trouble
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Asthma
- ☐ Colds
- ☐ Deafness
- ☐ Ear noises
- ☐ Enlarged Thyroid
- ☐ Eye pain
- ☐ Failing vision
- ☐ Venereal Disease

- ☐ Tuberculosis
- ☐ Bruise easily
- ☐ Hay fever
- ☐ Nosebleeds
- ☐ Sinus infection
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Anemia
- ☐ Stroke
- ☐ Chest pain
- ☐ Difficult breathing
- ☐ Pleurisy
- ☐ Spitting

- ☐ Itching
- ☐ Varicose veins
- ☐ Bed-wetting
- ☐ Frequent urination
- ☐ Kidney infection or stone
- ☐ Prostate trouble
- ☐ Cramps or backache
- ☐ Excessive menstrual flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Lumps in breast
- ☐ Alcoholism
- ☐ Diabetes
- ☐ Polio
- ☐ Swelling of ankles
- ☐ Cancer

HABITS:	Heavy	Moderate	Light	None
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				

Do you now take Vitamins or minerals? ☐ Yes ☐ No

Do you think you may need to take vitamins or minerals? ☐ Yes ☐ No

Are you wearing:
☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

PLEASE PRINT

Purpose of this appointment (Major Complaint) _____

_____

_____

What activities aggravate your condition? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other _____

_____

How long has it been since you really felt good? _____

What do you believe is wrong with you? _____

Other Doctors seen for this condition _____

Have you been treated for any health conditions by a physician in the last year? ☐ Yes ☐ No

Describe _____

What medications or drugs are you taking? _____

Remarks and additional information _____

_____

_____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment _____

Are you Insured? ☐ Yes ☐ No Company _____

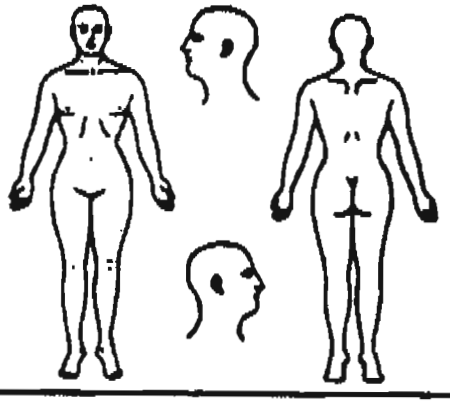
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. 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.

Patient's Signature _____ Date_____

Guardian or Spouse's Signature Authorizing Care _____ Date_____

Information Taken by _____ Date_____

Please mark your areas of pain on the figures below.



List the conditions that you are most interested in getting corrected. List in order of importance:

1. _____
2. _____
3. _____
4. _____

COMMENTS:

_____

_____

_____

_____

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_____

_____

_____

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