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 ______________________________

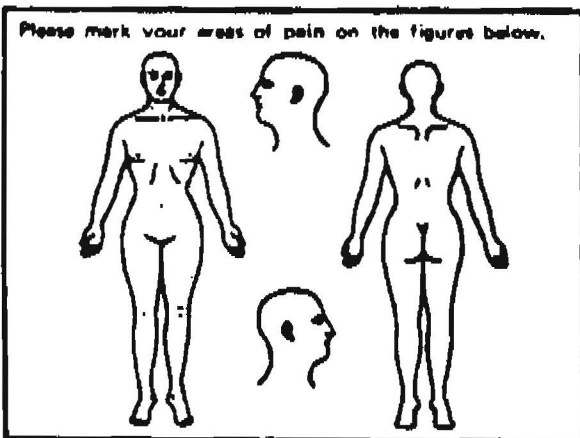
Are you Insured? ☐ Yes ☐ No Company ______________________________

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 ______________



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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