CONFIDENTIAL PATIENT INFORMATION

Today's Date: ____________________

Name: ____________________________________ Date of Birth: ____________________

Your address: ____

City: ___________________________________ State: _________ Zip: ______________

Gender (please circle): male / female Social Security Number: ______ - ____ - ________

Home Phone: (____) _______________ Work Phone: (____) ______________ Ext ____

Cell Phone: (____) ________________ Email Address: ______________________________

Employer: ____

Address: ____

City: ___________________________________ State: _________ Zip: ______________

Patient's Occupation (s): ____

Marital Status (please circle): S M D W No. of Childern: ____________________

Spouse's Name: ____

Spouse's Occupation: ____

Spouse's Work Phone: (____) ____________________

WHO MAY WE THANK FOR REFERRING YOU? __________________________________

CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize Dr. McGahey to administer chiropractic care to my (circle one):

Son / Daughter ____
Name of Child

Today's Date: ____

Signed: ____
Parent or Guardian

HISTORY

Please list your health concerns in order of decreasing severity (most severe first):

1. ______________________________ Severity: (1=mild, 10=horrible) ________

When did it start?: ______________ Has it happened before?: ________

How did it start?: ______________________________

2. ______________________________ Severity: (1=mild, 10=horrible) ________

When did it start?: ______________ Has it happened before?: ________

How did it start?: ______________________________

3. ______________________________ Severity: (1=mild, 10=horrible) ________

When did it start?: ______________ Has it happened before?: ________

How did it start?: ______________________________

4. ______________________________ Severity: (1=mild, 10=horrible) ________

When did it start?: ______________ Has it happened before?: ________

How did it start?: ______________________________

5. ______________________________ Severity: (1=mild, 10=horrible) ________

When did it start?: ______________ Has it happened before?: ________

How did it start?: ______________________________

6. ______________________________ Severity: (1=mild, 10=horrible) ________

When did it start?: ______________ Has it happened before?: ________

How did it start?: ______________________________

7. ______________________________ Severity: (1=mild, 10=horrible) ________

When did it start?: ______________ Has it happened before?: ________

How did it start?: ______________________________

Do any of these problems run in your family? (Please explain) ________________________

____

____

What have you done for this condition? Was it of benefit to you? ____________________

____

____

____

Is this condition interfering with your: work _____ sleep _____ daily routine _____

Please explain: ____

Are you unable to take part in certain activities that you normally enjoy (or do you enjoy them less) because of this condition? Sports, exercise, garden, pick up kids, etc. Please explain:

____

____

Have you been forced or felt the need to make any changes to your lifestyle because of

this condition/injury/pain? If so, what? ____

____

____

Would you consider making positive changes to your lifestyle if it would help you be

healthier and enjoy life more? ____

If you start to feel 'better' will you consider making these changes more permanent, or will

you go back to your old ways? ____

GENERAL HEALTH

Your feet provide the foundation for your spine and body, and help support you when you stand, walk or run. Please answer the following questions to the best of your ability:

How many hours are you on your feet during an average day? ________________________

What type of physical activity or exercise are you currently engaged in (walking, running, playing sports, etc.)?

____

____

Do you ever suffer from any of the following:

Foot Pain	**YES**	**NO**	Plantar Fasciitis	**YES**	**NO**
Heel Pain	**YES**	**NO**	Arch Pain	**YES**	**NO**
Knee Pain	**YES**	**NO**	Hip Pain	**YES**	**NO**

Cramping, aching or tired legs **YES** **NO**

Shoulder, arm, wrist or hand pain **YES** **NO**

Have you been diagnosed with arthritis? **YES** **NO** **DON'T KNOW**

If YES, Please explain: ____

Are you currently taking any nutritional supplements? **YES** **NO**

If YES, please list: ____

____

____

Please rate your overall stress level on a scale from 1 to 10 (1=mild, 10=off the charts) _______________

What are the greatest sources of stress in your life: ___________________________________

____

Please check all that apply to you:

___ Poor sleep
___ Ringing in ears
___ Stomach problems
___ Headaches
___ Dizziness
___ Asthma
___ Arthritis
___ Wear orthotics/heel lift
___ Constipation
___ Numbness/Tingling
___ High Blood Pressure
___ High Cholesterol
___ Low energy
___ Sinus problems
___ Heartburn

Name and address of your family physician: ____

____

Please list all surgeries and approximate dates:

DATE	TYPE OF SURGERY	COMPLICATIONS

Please indicate any diagnostic procedures you have undergone in the past:

STUDY	NO	YES	DATE	RESULTS
X-RAYS				
MRI				
CT SCAN				
BONE SCAN				
OTHER: ________________				

Is there anything else that has not been discussed which you may want us to know about?

____

____

____