mclaughlin
FAMILY CHIROPRACTIC
Empowering Lives...One Spine At A Time!

Name: _____ Age: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Work: _____ Cell: _____

Email: _____ Male: _____ Female: _____

Social Security # _____ Date of Birth: _____

Occupation: _____

Employer Name and Address: _____

❑ Single: _____ ❑ Married: _____ Spouse's Name: _____

Have you seen a Chiropractor before? ❑ Yes ❑ No When? _____

Whom may we thank for referring you to our office? _____

Insurance policy holder: _____ Date of Birth: _____

## Your Health Summary

*Please check all symptoms you have ever had, even if they do not seem related to your current problem.*

| | | | |
|---|---|---|---|
| ❑ Headaches | ❑ Pins and Needles/legs | ❑ Fainting | ❑ Neck pain |
| ❑ Pins and Needles/arms | ❑ Loss of smell | ❑ Back pain | ❑ Loss of balance |
| ❑ Dizziness | ❑ Buzzing in ears | ❑ Ringing in ears | ❑ Nervousness |
| ❑ Numbness in fingers | ❑ Numbness in toes | ❑ Loss of taste | ❑ Stomach upset |
| ❑ Fatigue | ❑ Depression | ❑ Irritability | ❑ Tension |
| ❑ Sleeping problems | ❑ Neck stiff | ❑ Cold hands | ❑ Cold feet |
| ❑ Diarrhea | ❑ Constipation | ❑ Fever | ❑ Hot flashes |
| ❑ Cold sweats | ❑ Lights bother eyes | ❑ Problem urinating | ❑ Heartburn |
| ❑ Mood swings | ❑ Menstrual pain | ❑ Menstrual irregularity | ❑ Ulcers |

List any medications you are taking: _____

_____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability. _____

I understand and agree that the amount paid to McLaughlin Chiropractic for X-ray studies is for the examination only and the X-ray negatives will remain the property of the clinic, being on file where they may be seen at anytime by a practice member of this clinic.

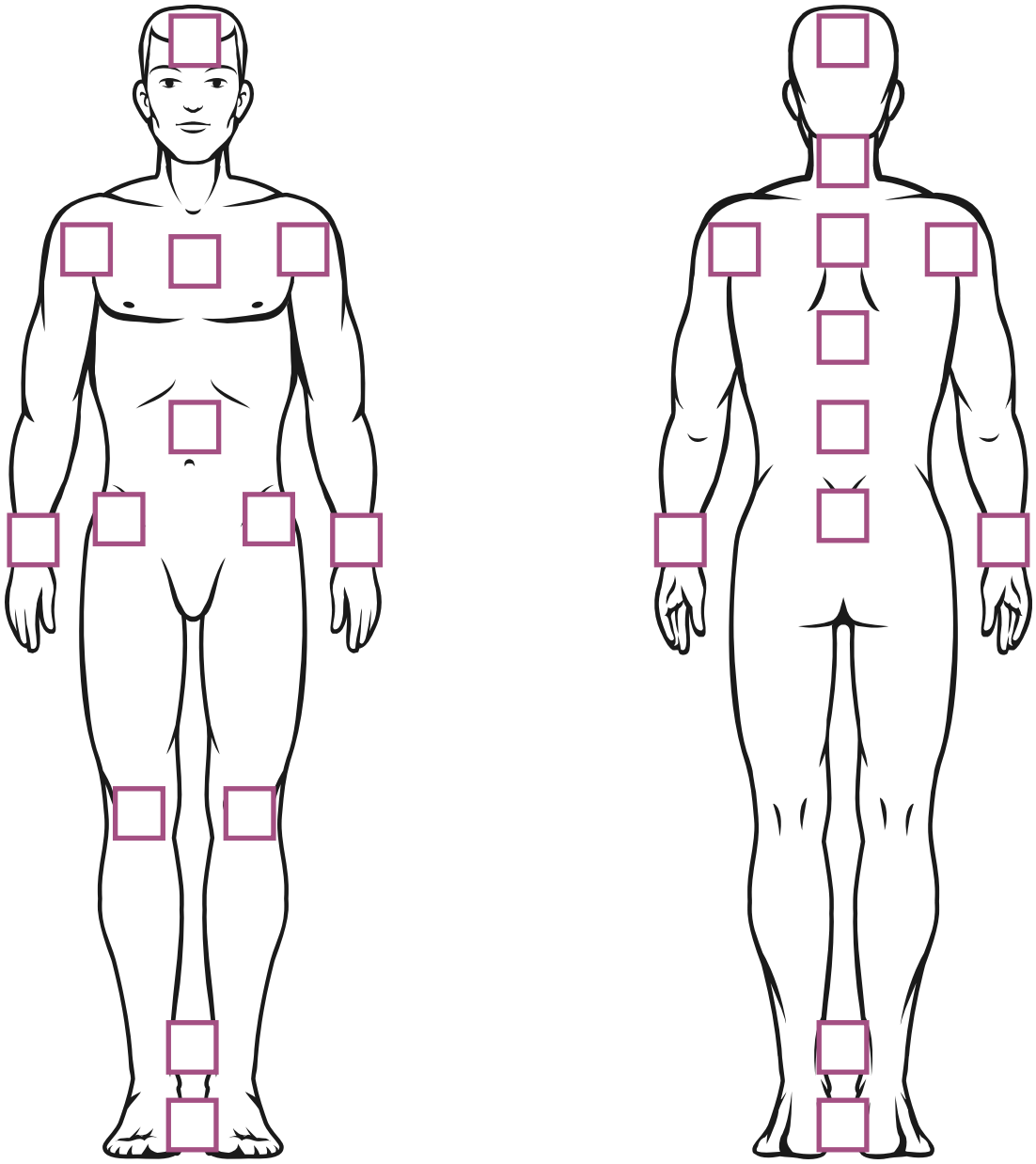
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand that I am personally responsible for payment of any services not covered by my insurance. I also understand that any fees for professional services rendered to me will be immediately due and payable. I give permission for the insurance to pay the doctor directly.

Signature: _____ Date: _____

# Pain Assessment

Rate your pain from 1 (light) to 10 (severe).

Please indicate the areas of your pain in the above figures using the number level of pain.



Comments: _____

_____

_____

_____

_____

# Chiropractic Informed Consent To Treat

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded If I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if i have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient Printed:_____ Name of Guardian Printed: _____

Signature of Patient:_____ Signature of Guardian: _____

Date: _____

Doctor of Chiropractic Name: _____

Signature of Doctor of Chiropractic: _____

Date: _____

# Patient's Personal and Family Health History

*It is important to read the following before filling out this form.*

Any and all physical events that our body goes through leaves obvious and in most cases not so obvious findings. Therefore, it is important you take time and thoughtfully (as well as honestly) answer all the following questions. Even the ones you believe we have already verbally asked you.

1. Have you ever fractured any bones in your body at any time, ever? (Please explain each with dates.)

   _____

2. How do you sleep?

   ❑ Stomach
   ❑ Side
   ❑ Back

   Quality of sleep?

   ❑ Very Peacefully
   ❑ Restlessly
   __ Number of Hours Per Night

3. What are your favorite hobbies and activities? How often do you participate in them? (Times per week/ hours per time)

   _____

4. How would you rate your energy level overall, prior to your present findings, on a scale of 1 to 10? (10 being the best)

   _____

5. Do you ever experience headaches more than one time per year? if so, please describe, how often, location, and duration.

   _____

6. Is your Mom still alive?

   ■ Yes
   ❑ No

7. Is your Dad still alive?

   ■ Yes
   ❑ No

# Health History Continued

8. If you answered ***No*** In Question 6 or 7, Please describe the reason for their passing, if applicable.
   If ***Yes*** please describe their current health status.

   _____

   _____

   _____

9. Once again, describe the current problem area you have consulted us for.

   _____

   _____

10. When this current problem is at its absolute worst, in what ways does it interfere (reduce your productivity or effectiveness) with your daily activities?

    _____

    _____

11. If this problem was left unattended for another five years, how do you think it would affect you? Would it just disappear?

    _____

    _____

12. On a scale of 1 to 10, 10 being the greatest you ever felt in your entire life, when would you say that it was you felt a 10? And what do you attribute that to?

    _____

    _____

13. On that same scale, when this problem has been at its absolute worst, where would you have rated yourself?

    _____

    _____

14. Have you ever smoked? ❑ Yes ❑ No
    Do you currently smoke? ❑ Yes ❑ No
    If ***Yes***, how often? _____ Packs Per Week.