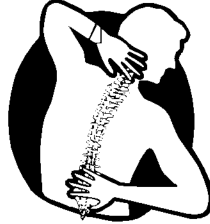
McPhail



Chiropractic

Dr. Drew K. McPhail

# PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature: ___________________________________________

Date: ____________________

# PATIENT APPLICATION SURVEY

Name: ____________________________________________________ (Age) ______ Gender: M F
Home Address: _____________________________________________ Home Phone: ( ) ______________________
City, State, Zip: ____________________________________________ Work Phone: ( ) ______________________
Email Address: _____________________________________________ Cell Phone: ( ) ______________________
Birth Date: _____ / _____ / ______ Social Security #: _______ - _____ - ________ Marital Status: S M D W
Names of Children: ____________________________________________________________ Ages: ___________________
Occupation: ____________________________________________ Employer Name: ______________________________
Spouse's Name: _______________________ Work Phone: ( ) ________________ Cell Phone: ( ) _________________
Spouse's Employer: ____________________________________ Occupation: _____________________________________
Referred to this Office by: Friend/Family Member - Name? ___________________________
Internet Yellow Pages Mail Clinic Location Other____________________
Payment for Services will be by: Cash Check Credit Card Health Insurance Automobile Insurance Worker's Compensation
Name of Insurance Co.:___________________________Insured's Employer: _____________ Insured's date of birth:_____________
Are you covered by more than one insurance company? Yes No Name _______________________________

# FAMILY HEALTH HISTORY

S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

| S | M | F | | S | M | F | | S | M | F | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | AIDS | | | | dislocated joints | | | | neck pain |
| | | | anemia | | | | epilepsy | | | | nervousness |
| | | | arthritis | | | | kyphosis | | | | numbness |
| | | | asthma | | | | headaches | | | | polio |
| | | | back pain | | | | heart trouble | | | | poor circulation |
| | | | bladder trouble | | | | reproductive disorder | | | | hepatitis |
| | | | bone fracture | | | | high blood pressure | | | | rheumatic fever |
| | | | cancer | | | | HIV/ARC | | | | rheumatism |
| | | | chest pain | | | | kidney disorder | | | | scoliosis |
| | | | concussion | | | | bowel control loss | | | | serious injury |
| | | | convulsions | | | | menstrual cramps | | | | sinus trouble |
| | | | diabetes | | | | multiple sclerosis | | | | tuberculosis |
| | | | indigestion | | | | muscular dystrophy | | | | venereal disease |

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

Describe Condition___________________________________ Date of Last Physical Exam_________

SURGICAL HISTORY:
1.______________________________________________ Date:_______________
2.______________________________________________ Date:_______________
3.______________________________________________ Date:_______________

Have you ever had a metal implant? Yes No Ever been gunshot? Yes No

ACCIDENT HISTORY
Job Auto Other 1. ____________________________________ Date:_______________
Job Auto Other 2.____________________________________Date:_______________
Job Auto Other 3.____________________________________Date:_______________

Reviewed by: ______________________________________ Date:____________

# PURPOSE OF THIS VISIT

**PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:**
( Rate your pain from 1-10. 1-being the least, and 10-being the worst.) Rating

1.______________________________________________________________ ________

2.______________________________________________________________ ________

3.______________________________________________________________ ________

4.______________________________________________________________ ________

5.______________________________________________________________ ________

6.______________________________________________________________ ________

SYMPTOMS ARE WORSE IN MORNING AFTERNOON NIGHT

WHEN AND HOW OCCURRED?________________________________________________________________

________________________________________________________________

**SYMPTOMS DEVELOPED FROM:** JOB RELATED INJURY AUTO ACCIDENT OTHER ACCIDENT ILLNESS UNKNOWN CAUSE GRADUAL ONSET DATE OCCURRED:____/____/_____________

**SYMPTOMS HAVE PERSISTED FOR**: ____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)

**SYMPTOMS/COMPLAINTS:** COME & GO NEARLY CONSTANT ARE CONSTANT

**HAVE YOU EVER HAD THIS BEFORE:** NO YES WHEN?_______________________________________

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?
_______________________________________________________ _____________________________________

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):
____________________________________________________________________________________________
____________________________________________________________________________________________

ARE YOU ALLERGIC TO ANY MEDICATIONS NO YES WHAT KIND?______________________________
ARE YOU TAKING ANY MEDICATIONS NO YES WHAT KIND?_________________________________
ARE YOU PREGNANT NO YES DATE OF LAST MENSTRUAL PERIOD____________

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:**
BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD LIFTING SNEEZING WALKING LYING DOWN STANDING

**PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION**:
BENDING HEAT ICE LIFTING LYING DOWN MEDICATIONS REACHING RESTING SITTING STANDING STRETCHING TURNING HEAD WALKING

**PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING:**
BLURRED VISION BUZZING IN THE EARS COLD FEET COLD HANDS COLD SWEATS
CONCENTRATION LOSS/CONFUSION CONSTIPATION DEPRESSION/WEEPING SPELLS DIARRHEA DIZZINESS FLUSHED FACE
FAINTING FATIGUE FEVER HEAD SEEMS TOO HEAVY HEADACHES INSOMNIA LIGHT BOTHERS EYES LOSS OF BALANCE LOSS OF SMELL LOSS OF TASTE LOW RESISTANCE TO COLDS MUSCLE JERKING NUMBNESS IN THE FINGERS
NUMBNESS IN TOES PINS AND NEEDLES IN ARMS PINS AND NEEDLES IN LEGS RINGING IN EARS SHORTNESS OF BREATHE
STIFF NECK STOMACH UPSET

Patient's Signature: __________________________________________ Date:______________________

Reviewed by: ____________________________________________ Date: ___________________

# HEALTH / LIFESTYLE

SOCIAL HISTORY

| | | | | |
|---|---|---|---|---|
| Tobacco usage | None | Light | Moderate | Heavy |
| Alcohol usage | None | Light | Moderate | Heavy |
| Drug usage | None | Light | Moderate | Heavy |
| Exercise | Never | Seldom | Occasional | Regularly |

Do you drink coffee? Yes No How many cups / day? ____________________________________________________________________

Do you take any supplements (i.e. vitamins, minerals, herbs)? ___________________________________________________________________

# EXPERIENCE WITH CHIROPRACTIC

Have you seen a Chiropractor before? ☐ Yes ☐ No Who? __________________________________ When? _____________________
Reason for visits: ___________________________________________________________________________________________________
How did you respond? ________________________________________________________________________________________________
Did your previous chiropractor take before and after x-rays? ☐ Yes ☐ No
Did you know posture determines your health? ☐ Yes ☐ No
Are you aware of any of your poor posture habits? ☐ Yes ☐ No
Explain: _____________________________________________________________________________________________________________
Are you aware of any poor posture habits in your spouse or children? ☐ Yes ☐ No
Explain: _____________________________________________________________________________________________________________

The most common postural weakness is Forward Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or fell like you carry your head forward, noticed a rounding of your shoulders or a developing "hump" at the base of your neck? Yes No

Date: _________________

# RADIOGRAPH CONSENT

I ___________________________________ do hereby give my consent to allow McPhail Chiropractic and it's representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant _______ ( Initial )

Signature of Patient/or Guardian of said Minor ____________________________________ Date ___________

## ACKNOWLEDGEMENT OF RECEIPT & NOTICE OF PRIVACY PRACTICES

I ___________________________ understand and have been provided with a notice of information practices that provides me a more complete description of information uses and disclosures, I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent
* The right to object to the use of my health care information for directory purpose
* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

Signature of Patient/or Guardian of said Minor ____________________________________ Date __________

Reviewed by: _________________________________ Date: __________________

# HEALTHCARE AUTHORIZATION FORM

I authorize and agree to allow the doctor and/or rehabilitation specialist to work with my spine through the use spinal adjustments and rehabilitative treatments and exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

The Doctor and/or rehabilitation specialist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, are not related to the spinal structural conditions diagnosed at this clinic, or are not within the chiropractic scope of practice for this state.

I authorize McPhail Chiropractic to send/receive and request records of all health information available for the purpose of gaining a thorough understanding of my condition to increase the success of my treatment. This includes but is not limited to: examination findings, X-Ray, MRI, CT, and any other diagnostic studies including all associated reports.

I give permission to McPhail Chiropractic to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a doctor or rehabilitation specialist in private, the doctor or specialist will provide a private room for these conversations.

I also clearly understand that if I do not follow the doctors and/or rehabilitation specialist specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the doctor and/or clinic for all services rendered.

| ______________________ | ____________ | ____________________ | __________ |
|---|---|---|---|
| Patient's Name Printed | Date | Patient's signature | Date |

| ______________________ | __________________________________ | __________ |
|---|---|---|
| Minors Name | Guardian/Spouse's Signature of Authorizing care for minor | Date |