



McPHAIL
CHIROPRACTIC CLINIC
Dr. Drew K. McPhail, D.C.

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: _____
How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit: _____
Is this purpose related to an auto accident / work injury? Yes No If so, when: _____
Describe: _____
Please describe the pain & its location: _____
When did this condition begin? ____/____/____ When did you first notice it? _____
Is this condition getting worse? Yes No Is this condition: Constant Comes & goes Activity related
Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____
What activities aggravate your symptoms? _____
Is there anything, which has relieved your symptoms? Yes No Describe: _____
Have you experienced this condition before? Yes No If so, please explain: _____
Who have you seen for this? _____ What did they do? _____
How did you respond? _____

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

FAMILY HEALTH HISTORY

Have any of your family members ever been diagnosed with the following:

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Infectious disease | <input type="checkbox"/> Gall bladder |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> epilepsy | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Other: _____ | | | |

AUTHORIZATION CARE

I authorize and agree to allow the doctor and/or physical therapist to work with my spine through the use spinal adjustments and rehabilitative 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.

The Doctor and/or physical therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the doctors and/or physical therapist 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 physical therapist 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

IN CASE OF EMERGENCY

Name _____

Relationship _____

Work Phone _____

Home Phone _____

Cell Phone _____

INSURANCE INFORMATION

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.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services [] YES [] NO

Patients Signature _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____

I hereby authorize McPhail Chiropractic to administer care as deemed necessary to my child, a minor under the age of 18 years old.

Name of Insurance Co. _____ Policy# _____

Address _____ Phone # _____

Insured's Name _____ Insured's SS# _____

Relationship to Insured _____ Birthdate ____/____/____

Employer _____

Who should receive charges on your account?

- Patient Spouse Parent/Guardian Workers Comp Auto Insurance
 Medicare Personal Health Insurance

RADIOGRAPH CONSENT

I _____ do hereby give my consent to allow McPahail 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 _____

HEALTHCARE AUTHORIZATION FORM

THE FOLLOWING AUTHORIZES MCPHAIL CHIROPRACTIC TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to McPhail Chiropractic to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

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 physical therapist in private, the doctor or therapist will provide a private room for these conversations.

By signing the following you are giving McPhail Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above

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: _____ Date: _____

Analysis: Pettibon

Diagnosis: (1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____

Patient Accepted for Postural Corrective Care YES NO Referred out _____

Doctor's Signature _____ Date _____

Neck Pain and Disability Index

Name: _____ Chart #: _____ Date: _____

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. In each section, please fill in ONE circle only which most closely describes your problem.

Section 1 - Pain Intensity

- A. I have no pain at the moment.
- B. The pain is very mild at the moment.
- C. The pain is moderate at the moment.
- D. The pain is fairly severe at the moment.
- E. The pain is very severe at the moment.
- F. The pain is the worst imaginable at the moment.

Section 2 - Personal Care

- A. I can look after myself normally without causing extra pain.
- B. I can look after myself normally but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help but manage most of my personal care.
- E. I need help every day in most aspects of self care.
- F. I do not get dressed, I wash with difficulty and stay in bed.

Section 3 - Lifting

- A. I can lift heavy weight without extra pain.
- B. I can lift heavy weight but it gives extra pain.
- C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- D. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- E. I can lift very light weights.
- F. I cannot lift or carry anything at all.

Section 4 - Reading

- A. I can read as much as I want with no pain in my neck.
- B. I can read as much as I want with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I can't read as much as I want because of moderate pain in my neck.
- E. I can hardly read at all because of severe pain in my neck.
- F. I cannot read at all.

Section 5 - Headaches

- A. I have no headaches at all.
- B. I have slight headaches which come infrequently.
- C. I have moderate headaches which come infrequently.
- D. I have moderate headaches which come frequently.
- E. I have severe headaches which come frequently.
- F. I have headaches almost all the time.

Section 6 - Concentration

- A. I can concentrate fully when I want with no difficulty.
- B. I can concentrate fully when I want with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want.
- D. I have a lot of difficulty in concentrating when I want.
- E. I have a great degree of difficulty in concentrating when I want.
- F. I cannot concentrate at all.

Section 7 - Work

- A. I can do as much work as I want.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I can hardly do any work at all.
- E. I cannot do my usual work.
- F. I can't do any work at all.

Section 8 - Driving

- A. I can drive my car without any neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain.
- D. I can't drive my car as long as I want because of moderate pain.
- E. I can hardly drive at all because of severe pain in my neck.
- F. I can't drive my car at all.

Section 9 - Sleeping

- A. I have no trouble sleeping.
- B. My sleep is slightly disturbed (less than 1 hr. sleepless).
- C. My sleep is mildly disturbed (1-2 hrs. sleepless).
- D. My sleep is moderately disturbed (2-3 hrs. sleepless).
- E. My sleep is greatly disturbed (3-5 hrs. sleepless).
- F. My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 - Recreation

- A. I am able to engage in all recreational activities with no neck pain.
- B. I am able to engage in all my recreational activities, with some pain in my neck.
- C. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain.
- F. I can't do any recreational activities at all.

Office Use Only

Score: _____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____

Revised Oswestry Low Back Pain and Disability

Name: _____ Chart #: _____ Date: _____

Please Read Instructions:

This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage in everyday life. In each section, please fill in ONE circle which most closely describes your problem.

Section 1 - Pain Intensity

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain comes and goes and is very severe.
- F. The pain is severe and doesn't vary much.

Section 2 - Personal Care

- A. I can look after myself normally without causing extra pain.
- B. I can look after myself normally but it causes extra pain.
- C. It is painful to look after myself and I am slow and careful.
- D. I need some help but can manage most of my personal care.
- E. I need help every day in most aspects of self care.
- F. I do not get dressed, I wash with difficulty and stay in bed.

Section 3 - Lifting

- A. I can lift heavy weight without extra pain.
- B. I can lift heavy weight but it gives extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned.
- E. Pain prevents me from lifting heavy weights, but I can manage light-medium weights if they are conveniently positioned.
- F. I can only lift very light weights at the most.

Section 4 - Walking

- A. I have no pain walking.
- B. I cannot walk more than one mile without increasing pain.
- C. I cannot walk more than 1/2 mile without increasing pain.
- D. I cannot walk more than 1/4 mile without increasing pain.
- E. I can walk with crutches.
- F. I cannot walk at all without increasing pain.

Section 5 - Sitting

- A. I can sit in any chair as long as I like.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than a half hour.
- E. Pain prevents me from sitting more than 10 minutes.
- F. I avoid sitting because it increases pain straight away.

Section 6 - Standing

- A. I can stand as long as I want without pain.
- B. I have some pain on standing but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for longer than 1/2 hour without increasing pain.
- E. I can't stand for longer than 10 minutes without increasing pain.
- F. I avoid standing because it increases the pain straight away.

Section 7 - Sleeping

- A. I get no pain in bed.
- B. I get pain in bed but it doesn't prevent me from sleeping well.
- C. Because of pain my normal night's sleep is reduced by < 1/4.
- D. Because of pain my normal night's sleep is reduced by < 1/2.
- E. Because of pain my normal night's sleep is reduced by < 3/4.
- F. Pain prevents me from sleeping at all.

Section 8 - Traveling

- A. I get no pain while traveling.
- B. I get some pain while traveling but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain prevents all forms of travel except that done lying down.

Section 9 - Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal but increases the degree of pain.
- C. Pain limits my more energetic interests, e.g. dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. I have hardly any social life because of the pain.

Section 10 - Changing Degree of Pain

- A. My pain is rapidly getting better.
- B. My pain fluctuates but overall is definitely getting better.
- C. My pain seems to be getting better but improvement is slow.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

Office Use Only

Score: _____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____