McCAULEY CHIROPRACTIC

CONFIDENTIAL PATIENT INFORMATION

WELCOME TO OUR OFFICE

Today's Date: _____/_____/_____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name _____ **Nick Name**_____

Last Name _____ **Middle Name**_____ **Suffix**_____

Address_____

City _____ **State** _____ **Zip Code** _____

Primary Phone _____ **Secondary Phone**_____

Mobile Phone _____

Home Email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address (es) provided

Which email address would you like us to use to communicate with you? *(Check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth _____/_____/_____ **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status (check one) ☐ Single ☐ Married ☐ Other **SS#**_____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Occupation_____ **Employed By** _____

Physical Address_____

City _____ **State** _____ **Zip Code** _____

Business Phone _____

Patient's Nearest Relative_____ **Phone**_____

Address_____

How were you referred to this office? _____

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

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Preferred Language *(check one)*

❑ English	❑ Spanish	❑ American Sign Language	❑ Chinese	❑ French	❑ German
❑ Tagalog	❑ Vietnamese	❑ Italian	❑ Korean	❑ Russian	❑ Polish
❑ Arabic	❑ Portuguese	❑ Japanese	❑ French Creole	❑ Greek	❑ Hindi
❑ Persian	❑ Urdu	❑ Gujarati	❑ Armenian	❑ I choose not to specify	

Verification Question *(choose only one question by checking the box next to the question, then give the answer to that question)*

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car?

Verification Answer to the Chosen question: _____

Answers must be at least 6 characters.

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker

If yes, how often do you smoke: ❑ Current every day smoker ❑ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

1) _____ **4)** _____
2) _____ **5)** _____
3) _____ **6)** _____

List any known allergies you have had to any medications. If no allergies are known, check here: ❑

1) _____ **3)** _____
2) _____ **4)** _____

Has any doctor diagnosed you with Hypertension (High Blood Pressure) presently? ❑ Yes ❑ No

If yes, describe: _____

Has any doctor diagnosed you with Diabetes presently? ❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? ❑ Yes ❑ No ❑ Not Sure

If yes, other comments regarding Diabetes: _____

FAMILY HISTORY: (circle as many as apply)

Mother: 1.) Cancer 2.) Diabetes 3.) Heart 4.) High Blood Pressure 5.) Respiratory Problems 6.) Stroke
If deceased – Age at death: _____

Father: 1.) Cancer 2.) Diabetes 3.) Heart 4.) High Blood Pressure 5.) Respiratory Problems 6.) Stroke
If deceased – Age at death: _____

Siblings: 1.) Cancer 2.) Diabetes 3.) Heart 4.) High Blood Pressure 5.) Respiratory Problems 6.) Stroke

SOCIAL HISTORY:

DO YOU: 1.) Exercise regularly_____ 2.) Eat a balanced diet_____ 3.) Obtain sufficient rest _____
DO YOU DRINK COFFEE/TEA? 1.) No 2.) Occasionally 3.) 1-2 cups / day 4.) 3-4 cups / day 5.) 5 or more cups / day
DO YOU DRINK ALCOHOL? 1.) No 2.) Occasionally 3.) 1-2 drinks / day 4.) 3-4 drinks / day 5.) 5 or more drinks / day

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MEDICAL HISTORY:

Date of last physical exam: _____ **By Whom:** _____

Have you ever been treated for any health conditions by a physician in the last year? ( ) Yes ( ) No

Describe: _____

Have you ever received Chiropractic care before? Yes_____ No_____ Where? _____

List operations/surgeries: _____

Unusual diseases: _____

Serious Illnesses: _____

Are You Pregnant? *(female)* ❑ Yes ❑ No

Have you ever suffered from:

- ❑ Heart trouble
- ❑ Diabetes
- ❑ High blood pressure
- ❑ Arthritis
- ❑ Asthma
- ❑ Bursitis
- ❑ Digestive Disorders
- ❑ Anemia
- ❑ Cancer
- ❑ HIV/AIDS

Have you ever?

Been knocked unconscious?	❑ Yes	❑ No
Been treated for a spine or nerve disorder?	❑ Yes	❑ No
Had a bone break or fracture?	❑ Yes	❑ No
Been hospitalized?	❑ Yes	❑ No

PRESENT HEALTH STATUS

What is your primary complaint?_____

_____

Have you had X-rays of this area within the past 12 months?
❑ Yes ❑ No

Has any other doctor seen you for this condition?
❑ Yes ❑ No

If yes explain:_____

_____

Is this appointment the result of an auto accident?
❑ Yes ❑ No

Is this appointment the result of an injury on the job?
❑ Yes ❑ No

Check symptoms you have noticed:

- ❑ Headaches
- ❑ Migraines
- ❑ Neck pain
- ❑ Neck stiffness
- ❑ Back pain
- ❑ Leg pain
- ❑ Arm pain
- ❑ Leg numbness
- ❑ Arm numbness
- ❑ Swollen joints
- ❑ Muscle spasm
- ❑ Sleep problems
- ❑ Fatigue
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Ear noise
- ❑ Dizziness
- ❑ Loss of balance
- ❑ Diarrhea
- ❑ Constipation
- ❑ Nausea
- ❑ Nervousness

Have you ever had the same or similar condition? Yes_____ No_____ If yes, When? _____

Describe _____