McCarthy Chiropractic

# Patient Information Form

Today's Date: _____

## ABOUT YOU

Name: _____ What you prefer to be called: _____

Birthdate: _____ Age: _____ Male ☐ Female ☐

Mailing Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Referred By: _____

Employer: _____ Occupation: _____

Marital Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name: _____ Any children? _____ How many? _____

## REASON FOR VISIT

The reason for this visit is a result of: ☐Sports ☐Trauma ☐Chronic ☐Other Explain what happened: _____ Please describe the pain and its location: _____

_____

When did the condition start? _____ Is it getting worse? ☐Y ☐N ☐Constant ☐Comes/Goes

Is the condition interfering with your: ☐Work ☐Sleep ☐Daily Routine

If so, please explain: _____

Have you had this or a similar condition in the past? ☐ Y ☐ N

If so, please explain: _____

Have you been treated by a medical physician for this condition? ☐ Y ☐ N

If so, where? _____

Have you ever been treated by a chiropractor before? ☐ Y ☐ N

If so, whom? _____ Phone: _____

## IN CASE OF EMERGENCY

Who should be contact? _____ Relation: _____

Home phone: _____ Work phone: _____

Who is your medical doctor? _____ Phone: _____

**HEALTH HISTORY**

Are you taking any of the following medications? ☐ Pain medication (including aspirin) ☐ Muscle relaxers ☐ Blood thinners ☐ Insulin ☐ Anti-Inflammatories ☐ Other(s) _____

Do you have or have you ever had any of the following diseases or conditions?

| | | |
|---|---|---|
| ☐ Heart Attack/Stroke | ☐ Heart Surgery/Pacemaker | ☐ Heart Murmur |
| ☐ Congenital Heart Defect | ☐ Mitral Valve Prolapse | ☐ Artificial Valves |
| ☐ Alcohol/Drug Abuse | ☐ Venereal Disease | ☐ Hepatitis |
| ☐ HIV+/AIDS | ☐ Shingles | ☐ Cancer _____ |
| ☐ Frequent Neck Pain | ☐ Emphysema | ☐ Anemia |
| ☐ High/Low Blood Pressure | ☐ Psychiatric Problems | ☐ Rheumatic Fever |
| ☐ Severe/Frequent Headaches | ☐ Kidney Problems | ☐ Ulcers/Colitis |
| ☐ Fainting/Seizures/Epilepsy | ☐ Sinus Problems | ☐ Asthma |
| ☐ Diabetes | ☐ Difficulty Breathing | ☐ Chemotherapy |
| ☐ Lower Back Problems | ☐ Artificial Bones/Joints | ☐ Arthritis |

Please list any other serious medical condition(s) you have or have ever had: _____

_____

Please list anything that you may be allergic to: _____

List previous surgeries/treatments with dates: _____

List any past serious accidents with dates: _____

Family health history: _____

**DO YOU**

Take supplements or vitamins? ☐ Y ☐ N Exercise? ☐ Y ☐ N

Are you on a special diet? ☐ Y ☐ N Since: _____

Do you smoke? ☐ Y ☐ N How much? _____ How long? _____

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

What is the age of your mattress? _____ Is it comfortable? ☐ Y ☐ N

**FOR WOMEN**

Are you taking birth control? ☐ Y ☐ N Are you pregnant? ☐ Y ☐ N

How far along? _____ Nursing? ☐ Y ☐ N

**ACCOUNT INFORMATION**

**Payment is due in full for all services rendered at the time of visit, unless other arrangements are made. If account is not paid within 90 days of date of service and no other financial arrangements have been made, you will be responsible for interest at the maximum legal rate, attorneys' fees, collection agency fees, and any other expenses incurred in collecting your account.*

**I authorize Dr. McCarthy to perform any necessary services needed during diagnosis and treatment.*

**I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform Dr. McCarthy of any changes to the information that I have provided.*

Signature_____ Date: _____

Print Name _____

McCarthy
Chiropractic

## Informed Consent to Chiropractic Adjustments and Care

I request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including modes of physiotherapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. McCarthy.

I have had an opportunity to discuss with Dr. McCarthy the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, 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, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, it is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure of any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interests. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, this clinic originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the clinic will agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Dr. McCarthy has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Name (Printed) Date Signed

_____

Signature (Patient or Legal Representative)