McGinnis Chiropractic New Patient Questionnaire

PLEASE PRINT ***Patient #___________***

Name_________________________ ____________________ Nickname_________________________
(last) (first) (if any)
Address______________________________ City___________________ State_____ Zip___________
(apt #)
❑Male ❑Female Date of birth_________________________ SS#___________________________
❑Married ❑Domestic Partner ❑Single ❑Widowed ❑Divorced ❑Separated
Home Phone__________________________________ Cell phone_______________________________
Work Phone__________________________ E-mail ____
Employer____________________________ Occupation___________________________ # years_____
Business Address________________________ City_________________ State____ Zip__________
Emergency Contact_________________ Phone _____________________ Relation_______________
Whom may we thank for referring you to us? ____
Name of local primary Physician_________________________________ May we contact them?______

SYMPTOMS

Main complaint____ How frequent?__________________
Is this due to an accident or injury?____
When did it start?________________________________ Getting better or worse?___________________
What activity bothers it the most? ____
When is it at its best?________________________ When is it at its worst?______________________
Rate the pain - (0 is pain free - 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10
Other chiropractors?_________________________________ Positive experience?________________
Other type of physician or therapist?____________________ Positive experience?________________
Secondary complaint____

HEALTH HISTORY- please circle all that apply

AIDS/ HIV	Allergy Shots	Anemia	Appendicitis	Arthritis	Asthma	Bleeding	Bronchitis
Cancer	Cataracts	Chicken pox	Chronic Fatigue	Depression	Diabetes	Eating Disorder	Emphysema
Epilepsy	Fibromyalgia	Fractures	Glaucoma	Gout	Heart dx	Hepatitis	Hernia
Herniated disc	High Blood Pressure	High Cholesterol	Implants	Kidney dx	Liver dx	Migraines	M.S.
Miscarriage	Mono	Osteoporosis	Parkinson's	Polio	Pacemaker	Pneumonia	Poor Circulation
Prostate	Prosthesis	Rheumatoid	S.T.D.	Stroke	Thyroid	Tonsillitis	Tuberculosis
Tumors	Ulcers	Weight gain/loss	Whooping cough		Other_______________		

Previous surgeries and dates ____
____
List all medications you are currently taking ____
____
What kind of exercise do you do? ______________________________How often?_______________
What supplements do you take?____
How much do you smoke per day?___________________ Drink per week? ______________________
Women only - How many children?______ Pregnant?_____ Nursing?_____ Birth control pills?______

*All above questions have been answered accurately, and I understand that giving incorrect information can be dangerous. I authorize this office to release any information pertaining to my treatment to third party payers or other health care providers. I authorize and request my insurance company to pay directly to this office any payable benefits. I further understand that payment may be less than the actual cost of services and I will be responsible for any outstanding amount owed this office**.** ***If insured, please provide copy of insurance card.***

Patient Signature_______________________________________Date__________________________

I have received and agree to read the following documents:

- HIPAA – Health Insurance Portability and Accountability Act
- Informed Consent - Doctor/Patient Relationship in Chiropractic
- McGinnis Chiropractic Insurance Policies and Guidelines

Patient Signature____**Date**___________________________

CONSENT TO TREATMENT OF MINOR

I being the parent or guardian of ____ ,

a minor, the age of _____________________________ do hereby consent, authorize and request Tina McGinnis, DC to administer such treatment deemed advisable, necessary or requested on the above minor.

I agree to hold her free and harmless from any claims, suits for damages or complications which may result from such treatment.

Parent/Guardian Signature_______________________________________ **Date**______________

Witness Signature____

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