McAdam Chiropractic
794 Route 202/206N
Bridgewater, NJ 08807

PATIENT INFORMATION & CONDITION FORM

NAME _____

Today's Date: ___/___/___ Birth Date: ___/___/___ Age: ____ Gender: F M

If you are under 18 years of age, please provide legal parent/guardian information:

Guardian: _____ Relationship_____

Phone: (_____) _____

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐Single

How many children_____Weight_____Height_____

CURRENT ADDRESS/PHONE

Street_____

City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

Email _____

Your Occupation _____

Employer _____

Work Phone (_____) _____

Student at _____

☐ FULL-TIME ☐ PART-TIME

Who should we contact in the event of an emergency?

_____ Phone (_____) _____

General Information Related to the Condition:

Is your condition or injury due to an *auto*-accident or work-related cause? ☐ YES ☐ NO

_____

Approximately WHEN did the conditions or symptoms begin to occur? ___/___/___

How OFTEN do you experience your symptoms?

☐ 1- Constantly (76-100% of the time) ☐ 2- Frequently (51-75% of the time)

☐ 3- Occasionally (26-50% of the time) ☐ 4- Intermittently (0-25% of the time)

Describe your condition, symptoms, or the purpose of this appointment:

_____

_____

Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe:

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____

Date of Last Visit: ___/___/____

Additional Information Related to the Condition:

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache

What caused it?

What aggravates it?

What relieves it?

Please check any of the following symptoms you are NOW experiencing:

☐ Headache ☐ Dizziness ☐ Light Bothers Eyes ☐ Diarrhea ☐ Head seems too heavy

☐ Neck Pain ☐ Loss of Memory ☐ Clumsiness ☐ Feet Cold ☐ Neck Stiff ☐ Ears Ring

☐ Hands Cold ☐ Sleeping Problems ☐ Tingling in legs/feet ☐ Tingling in arms/hands

☐ Face Flushed ☐ Nausea ☐ Back Pain ☐ Numbness in arms/hands ☐ Buzzing in Ears

☐ Constipation ☐ Nervousness ☐ Numbness in legs/feet ☐ Loss of Balance ☐ Cold Sweats

☐ Tension ☐ Shortness of Breath ☐ Fainting ☐ Fever ☐ Fatigue ☐ Irritability ☐ Loss of Smell

☐ Chest pain/rib pain ☐ Pain in arms/hands ☐ Pain in legs/feet ☐ Jaw pain ☐ Loss of strength arms

☐ Burning muscle pain ☐ Loss of strength legs ☐ Difficulty swallowing ☐ Sharp/shooting pain

Other: _____

Have you experienced changes to:

□ Eyes (sight) □ Ears (hearing) □ Nose (smell) □ Mouth (taste) □ Bladder

□ Bowels □ Sleep □ Emotion □ Appetite

Please Explain: _____

Have you missed work or school due to your injuries? ☐ Yes ☐ No

Medical History:

What surgery have you had? _____

When? _____

Serious illnesses or conditions? _____

When? _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe_____

_____

What medications or drugs are you taking?

_____

Intake: ☐Coffee ☐Tea ☐ Alcohol ☐Cigarettes ☐ White Sugar

Allergies_____

Do you now or have you ever had:

□ Heart Disease□ Diabetes □ Cancer □ Stroke □ High Blood Pressure □ Thyroid Problems

□ Tuberculosis □ Prostate Disorder □ Kidney Problems □ Asthma □ Ulcer □ Seizure Disorder

Other: _____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?

☐ YES ☐ NO ☐ UNCERTAIN

****

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

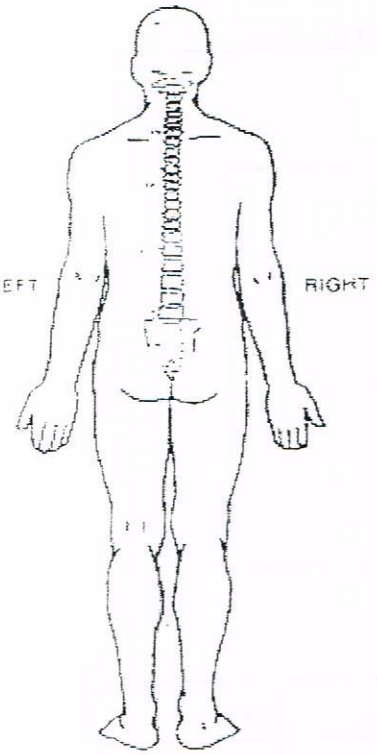
I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

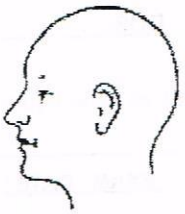
Patient's Signature: _____Date: ___/___/____

PATIENT CONSULTATION

By_____ D.C.

Name_____ Date_____





Major Complaints

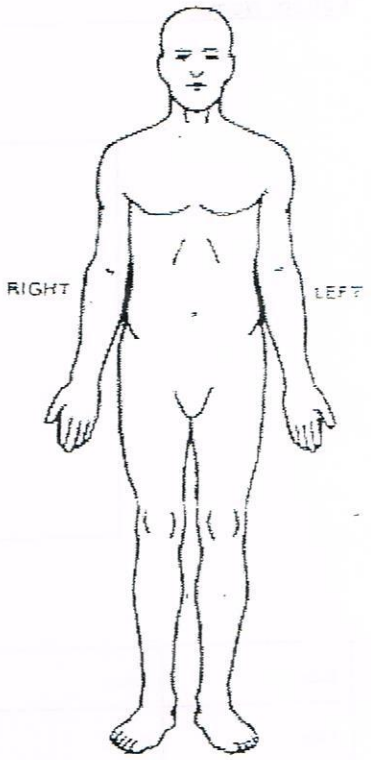
1 _____

2 _____

3 _____

4 _____

5 _____



When did the condition or symptoms begin to occur? _____/_____/_____

How did your symptoms start?

Average pain intensity: (Circle)

No pain 1 2 3 4 5 6 7 8 9 10

Describe your pain: (Circle)

Burning Sharp Dull Ache Radiating

How often do you experience your symptoms?

Constantly (76% - 100% of the time) Frequently (51% - 75% of the time)

Occasionally (26-50% of the time) Intermittently (0% - 25% of the time)