McAdam Chiropractic
794 Route 202/206 North
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

Weight:_____ Height_____

Number of children_____

Current Address/Contact/Work

Street _____

City _____ State _____ Zip _____

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

E-mail address: _____

Your Occupation _____

Employer _____ Work Phone (_____) _____

Student at _____ ☐ Full Time ☐ Part Time

Emergency Contact _____ 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/condition

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 ☐ Loss of Memory ☐ Heavy Head

☐ Difficulty Swallowing ☐ Jaw Pain ☐ Neck Pain ☐ Neck Stiff ☐ Clumsiness

☐ Ears Ring ☐ Buzzing in Ears ☐ Loss of Smell ☐ Face flushed ☐ Nervousness

☐ Fever ☐ Shortness of Breath ☐ Irritability ☐ Fatigue ☐ Sleeping Problems

☐ Cold Sweats ☐ Tension ☐ Fainting ☐ Nausea ☐ Constipation ☐ Diarrhea

☐ Back pain ☐ Chest Pain/Rib Pain ☐ Hands Cold ☐ Burning Muscle Pain

☐ Sharp/Shooting Pain ☐ Pain in arms/hands ☐ Tingling in arms/hands

☐ Numbness in arms/hands ☐ Loss of Strength in Arms ☐ Loss of Balance

☐ Pain in legs/feet ☐ Tingling in legs/feet ☐ Numbness in legs/feet

☐ Loss of Strength in Legs ☐ Cold Feet ☐ Other:_____

Have you experienced changes to:

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

☐ Bowels ☐ Sleep ☐ Emotion ☐ Appetite ☐ Describe:_____

Medical History:

What surgeries have you had? _____

_____ When?_____

Serious illness or conditions? _____

_____ When?_____

Have you been treated for any health conditions 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 ☐ Ulcers ☐ Seizure Disorder ☐ Other:_____

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

☐ Yes ☐ No ☐ Uncertain

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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 with the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature:_____ Date: ____/____/_____