

Patient Health Goals

Name and Date: _____

We all have desires regarding our health, and knowing these goals is very important to Dr. McKinnon. The more he can understand your desires for health, the better he can help you achieve optimal health and happiness. Understand that Dr. McKinnon has a near 100% success rate helping patients regain strength, vitality, fitness, and well being.

In order to get you better, please tell us your top health goals:

My primary desire is:

My secondary desire is:

Many patients report with pain, dysfunction, degeneration, and weakness. To better understand how your condition is affecting you, please inform the doctor of your primary fears and limitations that concern you with your health.

My primary concern or fear is:

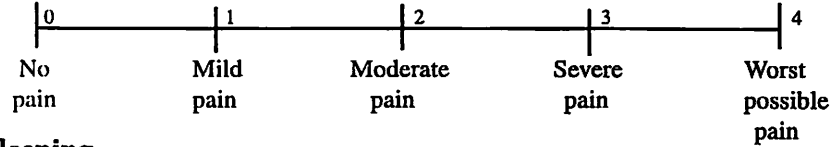
My secondary concern or fear is:

Functional Rating Index

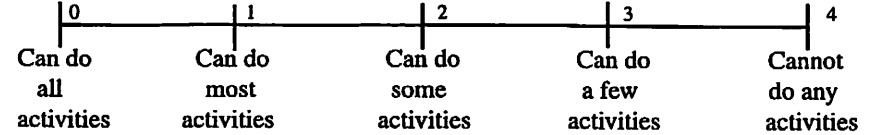
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

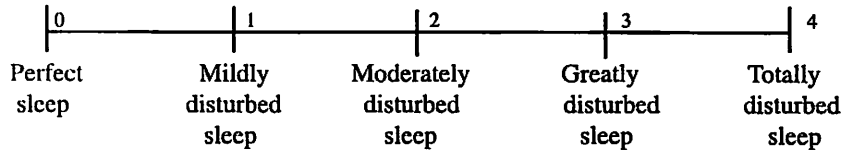
1. Pain Intensity



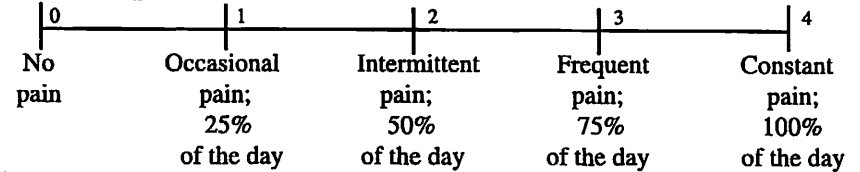
6. Recreation



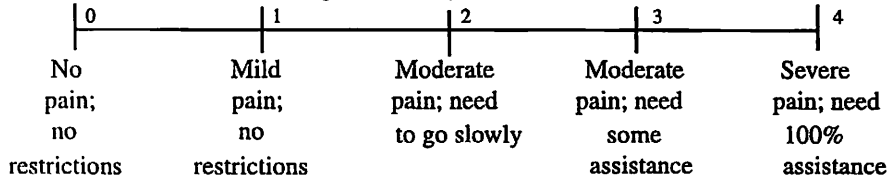
2. Sleeping



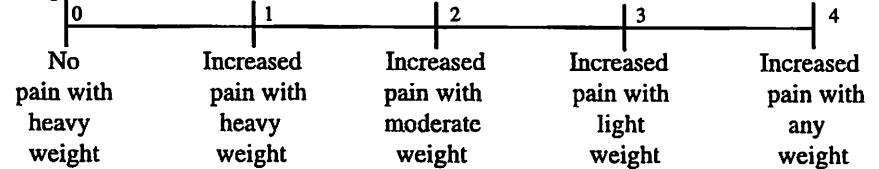
7. Frequency of pain



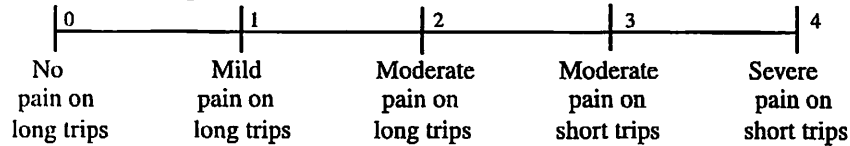
3. Personal Care (washing, dressing, etc.)



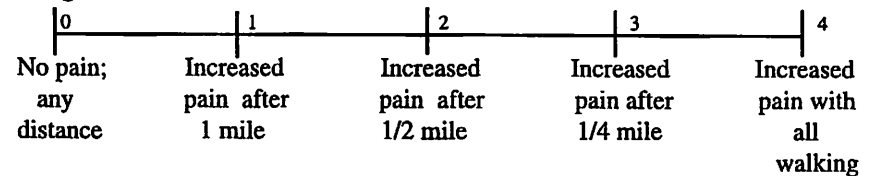
8. Lifting



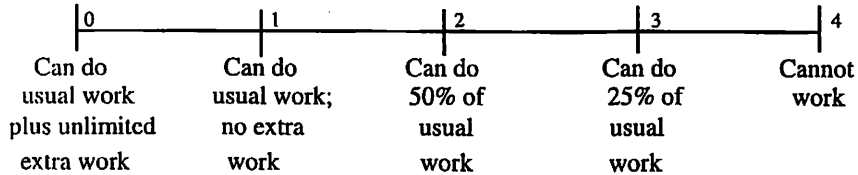
4. Travel (driving, etc.)



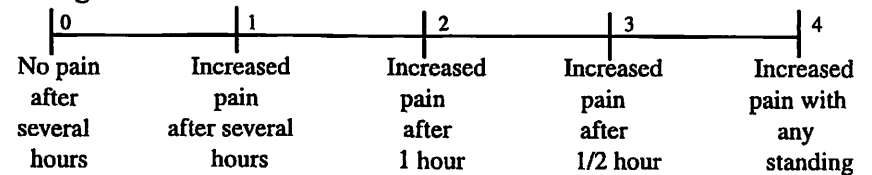
9. Walking



5. Work



10. Standing



Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

PRINTED

Signature

Date

**McKinnon Chiropractic Inc.
4605 Mill Branch Lane
Knoxville, TN 37938**

Notice of Privacy Practice Summary:

This summary discloses how health information about you may be used. A full notice of the privacy rights has also been provided to you.

McKinnon Chiropractic, Inc. uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care you receive.

McKinnon Chiropractic, Inc. will not disclose your information to others unless you tell us to do so, or unless the law authorized or requires us to do so.

McKinnon Chiropractic, Inc. may use your information to provide appointment reminders, information about treatment alternatives, or other health related issues.

McKinnon Chiropractic, Inc. may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donation research, health and safety government functions in order to comply with workers compensation laws and regulations. A right to request restriction, report and retain a copy of your health records.

You may complain to Murray McKinnon and the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

McKinnon Chiropractic, Inc. must maintain the privacy of protected health information, provide you with a notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restrictions on how your information is used and disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Clinical Summary Report (CCR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking McKinnon Chiropractic Inc. to save these electronically for me and not print them out after each visit. I understand that, upon request these reports are available to be printed or emailed to me for review.

If you have other questions or complainants please contact Murray McKinnon D.C. at 865-922-1476.

Patient Signature

Date

McKinnon Chiropractic Inc.
4605 Mill Branch Lane
Knoxville, TN 37938

Notice of Privacy Practice Summary:

This summary discloses how health information about you may be used. A full notice of the privacy rights has also been provided to you.

McKinnon Chiropractic, Inc. uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care you receive.

McKinnon Chiropractic, Inc. will not disclose your information to others unless you tell us to do so, or unless the law authorized or requires us to do so.

McKinnon Chiropractic, Inc. may use your information to provide appointment reminders, information about treatment alternatives, or other health related issues.

McKinnon Chiropractic, Inc. may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donation research, health and safety government functions in order to comply with workers compensation laws and regulations. A right to request restriction, report and retain a copy of your health records.

You may complain to Murray McKinnon and the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

McKinnon Chiropractic, Inc. must maintain the privacy of protected health information, provide you with a notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restrictions on how your information is used and disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Clinical Summary Report (CCR): I understand that a clinical summary report is created after each visit for the purpose of EHR and is available for my review. At this time, I am asking McKinnon Chiropractic Inc. to save these electronically for me and not print them out after each visit. I understand that, upon request these reports are available to be printed or emailed to me for review.

If you have other questions or complainants please contact Murray McKinnon D.C. at 865-922-1476.

Patient Signature

Date

Consent to Treatment Form

When you give your permission to have chiropractic spinal adjustments and physical medicine modalities performed you and your guardian should understand the most common risks and hazards of these procedures. These are all rather infrequent but may occur:

1. Post treatment discomfort, or soreness or stiffness, which may persist 12 to 24 hours after treatment.
2. Transient lightheadedness or dizziness following chiropractic adjustments of the neck. Please alert Dr. McKinnon should this reaction occur.
3. Aggravation of acute intervertebral disc bulge or herniation. Please be advised that Dr. McKinnon will make reasonable efforts to determine the possibility of an underlying disc problem and modify your treatment recommendations accordingly.
4. Spontaneous vertebral body or rib fracture in an osteoporotic patient. Please be advised that Dr. McKinnon will make every reasonable effort to diagnose this pre-existing condition and modify your treatment recommendations accordingly.
5. Acute onset of muscle spasms alongside the spine in the area being treated or in an adjacent area. These muscle spasm reactions are commonly present, even before treatment, in the acute patient and every effort will be made to reduce them prior to spinal adjustments.

I understand that no guarantee has been made and that the procedures may not cure my condition.

Authorization to Release Information: Assignment of Benefits

I hereby authorize assignee to release information to secure payment for my care at this facility. I hereby assign payment of my benefits, including major medical benefits to which I am entitled, private insurance or any other health plan to:

McKinnon Chiropractic Inc.
4605 Mill Branch Lane
Knoxville, TN 37938

A photo copy of this assignment is to be considered as valid as an original. This assignment remains in effect until evoked by me in writing.

I understand that I am financially responsible for all charges whether or not paid by insurance. If the account is placed in collections, additional charges equal to the cost of collections, including agency and attorney fees and court costs incurred and permitted by laws governing these transactions will be added to the amount due. These services and this agreement were entered into in the City of Knoxville in Knox County, TN.

Date: _____

Signature

Printed Name

Doctor's Statement: The patient (guardian) and I have discussed the procedures to be performed. To the best of my knowledge, the patient (guardian) understands the procedures and consents to them:

Dr. Murray D. McKinnon D.C.

Are you currently experiencing any of these symptoms? (Check all the apply)
Many of the following conditions respond to Chiropractic and Acupuncture treatment.

General: (constitutional)

- Recent Weight Change
Fever
Fatigue
None in this Category

Musculoskeletal:

- Low Back Pain
Mid Back Pain
Neck Pain
Arm Problems
Leg Problems
Painful Joints
Stiff/Swollen Joints
Sore/Weak Muscles or Joints
Muscle Spasms/Cramps
Broken Bones
Other:
None in this Category

Neurological:

- Numbness or tingling sensations
Loss of Feeling
Dizziness or light headed
Frequent or Recurrent Headaches
Convulsions or seizures
Tremors
Stroke
Have you ever had a head injury?
Ever been in an auto accident?
Other:
None in this Category

Mind/Stress:

- Nervousness
Depression
Sleep Problems
Memory Loss or Confusion
Other:
None in this Category

Genitourinary:

- Sexual Difficulty
Kidney Stones
Burning/Painful Urination
Change in force/strain w Urination
Frequent Urination
Blood in Urine
Incontinence or Bed Wetting
Other:
None in this Category

Gastrointestinal:

- Loss of Appetite
Blood in Stool
Change in Bowel Movements
Painful Bowel Movements
Nausea or Vomiting
Abdominal Pain
Frequent Diarrhea
Constipation
Other:
None in this Category

Cardiovascular & Heart:

- Chest Pains
Rapid or Heartbeat changes
Blood Pressure Problems
Swelling of Hands, Ankles, or Feet
Heart Problems
Other:
None in this Category

Respiratory:

- Difficulty Breathing
Persistent Cough
Coughing Blood
Asthma or Wheezing
Lung Problems
Other:
None in this Category

Eyes and Vision:

- Wear contacts/glasses
Blurred or double vision
Glaucoma
Eye disease or injury
Other:
None in this Category

Ears, Nose and Throat:

- Bleeding gums / mouth sores
Bad Breath or bad taste
Dental Problems
Swollen throat or voice change
Swollen glands in neck
Ringing in the ears
Ear - Ache/Ringing/Drainage
Sinus / Allergy problems
Nose Bleeds
Hearing Loss
Other:
None in this Category

Endocrine, Hematologic, and

Lymphatic:

- Thyroid problems
Diabetes
Excessive Thirst or urination
Cold Extremities
Heat or Cold intolerance
Change in hat or glove size
Dry skin
Glandular or hormone problem
Swollen Glands
Anemia
Easily Bruise or Bleed
Phlebitis
Transfusion
Immune system disorder
Other:
None in this Category

Skin and Breasts:

- Rash or Itching
Change in Skin Color
Change in hair or nails
Non-healing sores
Change of appearance of a mole
Breast Pain
Breast Lump
Breast Discharge
Other:
None in this Category

Women Only:

Are you pregnant?

- Yes - Due Date
No - Last Menstrual Period

- Infertility
Painful or Irregular periods
Vaginal Discharge
Other:
None in this Category

Pregnancies with Outcome & Date:

Comments:

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature Date

Treating Doctor Signature Date

Patient No:

PATIENT CASE HISTORY

The patient is a 45-year-old male with a long history of hypertension and diabetes mellitus. He was first diagnosed with hypertension at the age of 30 and has been on antihypertensive therapy ever since. His diabetes was diagnosed 10 years ago and is currently managed with insulin therapy.

He presented to the clinic today with a chief complaint of increasing fatigue and weakness over the past several weeks. He reports that he has lost approximately 10 pounds (4.5 kg) in the last 3 months, which is a significant weight loss for him. He also notes that he has been experiencing frequent urination, particularly at night, and increased thirst.

In addition to these symptoms, he has noticed some changes in his vision, specifically blurring and double vision, which have been present for about a month. He has no history of trauma or recent falls. His diet and exercise routine have remained relatively stable, though he admits to being somewhat sedentary due to his physical condition.

His medical history is significant for hypertension, diabetes mellitus, and hyperlipidemia. He is currently taking lisinopril for his blood pressure, insulin glargine and insulin lispro for his diabetes, and statin therapy for his cholesterol. He has no known drug allergies and is not taking any other medications.

On physical examination, the patient appears thin and well-appearing. His vital signs are stable. There is no tachycardia or tachypnea. The heart sounds are clear, and there are no murmurs. The lungs are clear to auscultation. The abdomen is soft and non-tender, with no organomegaly. The lower extremities show no edema or ulcers.

Laboratory investigations were performed, including a complete blood count (CBC), comprehensive metabolic panel (CMP), and HbA1c. The CBC is within normal limits. The CMP shows a significant increase in serum glucose levels, consistent with his known diabetes. There is also a mild elevation in serum creatinine, which may be related to his long-standing hypertension.

The HbA1c is elevated, indicating poor glycemic control. Further testing, including a fasting insulin level and a C-peptide level, is planned to evaluate his insulin production and sensitivity. An ophthalmology consultation is also being requested to assess the cause of his visual symptoms.

The patient is to be counseled on the importance of maintaining good glycemic control and the potential complications of uncontrolled diabetes. He will be scheduled for a follow-up visit in two weeks to review his laboratory results and discuss the next steps in his management.

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Began When? ____ / ____ / ____ **Describe how this began:** _____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes (Describe) _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both

Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both

Other Area: _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? (Describe) _____

For this CURRENT condition, have you:

• **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: _____ **Where?** _____

• **Had any previous Surgery or Interventions in this area?** (Describe) _____

• **Taken any Medications?** OTC / Prescriptions _____

• **Had any diagnostic testing?** X-rays / MRI / CT / Other: _____ **When and Where?** _____

Describe any Secondary Complaints: _____

HEALTH HISTORY - (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Medications:

Allergies to Medications: NONE (List) _____

Current Medications: NONE

(Already have a list? We can make a copy.) _____

Past Health History: (Please list any past...)

Surgeries - Date, Type, and Reason: NONE

Major Injuries/Traumas: NONE

Major Hospitalizations: NONE

Patient No: _____

Family Health History: (Please mark N/A if not relevant.)

List relevant major health problems of immediate relatives:

Deaths in immediate family: (Cause and at what Age?)

Social and Occupational History:

Level of Education Completed: _____

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: (Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)

Habits:

Cigarettes - (#/day) _____

Alcohol - (amount/day) _____

Coffee/Tea - (cups/day) _____

Rec. Drugs (List) _____

PATIENT CASE HISTORY

HISTORY OF CURRENT CONDITION

Describe Major Complaint: _____

Began When? ____ / ____ / ____ Describe how this began: _____

Grade Intensity/Severity of Complaint: None / Mild / Moderate / Severe / Very Severe

Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

How frequent is the complaint present? Off & On / Constant

Does this complaint radiate/shoot to any areas of your body? No / Yes (Describe) _____

Head - Base of Skull / Forehead / Sides-Temple R / L / Both

Leg - Hip / Thigh-Knee / Calf / Foot-Toes R / L / Both

Arm - Across Shoulder / Elbow / Hand-Fingers R / L / Both

Other Area: _____

Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

Does anything make the complaint worse? Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

Which daily activities are being affected by this condition? (Describe) _____

For this CURRENT condition, have you:

• Received any other treatment? None / DC / MD / PT / Massage / ER / Other: _____ Where? _____

• Had any previous Surgery or Interventions in this area? (Describe) _____

• Taken any Medications? OTC / Prescriptions _____

• Had any diagnostic testing? X-rays / MRI / CT / Other: _____ When and Where? _____

Describe any Secondary Complaints: _____

HEALTH HISTORY – (PLEASE USE THE REVERSE SIDE OF THIS PAGE IF ADDITIONAL SPACE IS NEEDED)

Medications:

Allergies to Medications: NONE (List) _____

Current Medications: NONE

(Already have a list? We can make a copy.) _____

Family Health History: (Please mark N/A if not relevant.)

List relevant major health problems of immediate relatives:

Deaths in immediate family: (Cause and at what Age?)

Past Health History: (Please list any past...)

Surgeries – Date, Type, and Reason: NONE

Social and Occupational History:

Level of Education Completed: _____

High School / Some College / College Grad. / Post Grad. / Other

Lifestyle: (Hobbies, Rec. Activities, Exercise, Diet, Work, Vitamins)

Major Injuries/Traumas: NONE

Habits:

Cigarettes – (#/day) _____

Alcohol – (amount/day) _____

Coffee/Tea – (cups/day) _____

Rec. Drugs (List) _____

Patient No: _____

INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: (Last, First MI) _____ Preferred Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home: _____ Mobile: _____ Mobile Carrier: _____ Work: _____
Email: _____ Gender: M / F Marital Status: Married / Other / Single
Social Security #: _____ Date of Birth: _____
Student Status: Full Student / Part Student / Non-Student Employed Employer: _____
*Referred By: _____

Ethnicity: Hispanic or Latino / Other Preferred Language: _____
Race: Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White Smoking Status: Every Day / Some Days / Former / Never

EMERGENCY CONTACT INFORMATION

Full Name: _____ Primary Care Physician: _____
Home: _____ Mobile: _____ Doctor's Phone: _____
Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

Insurance Worker's Comp Self-Pay (Cash) Personal Injury/Auto Other (please explain): _____

PRIMARY INSURANCE

Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other
Other than Self:
Insured's Name: _____ Gender: M / F
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Date of Birth: _____

SECONDARY INSURANCE

Name: _____
Relation to Insured: Self / Spouse / Parent / Child / Other
Other than Self:
Insured's Name: _____ Gender: M / F
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Date of Birth: _____

Who is responsible for payment? Self / Other - (Relationship) _____

Other than Self:

Full Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Patient No: _____