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

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any 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 requestthese 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

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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 make 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 transactios will be added to the amount dure. 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.

REVIEW OF SYSTEMS

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

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*** _____

_____

_____

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 No: _____

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*** _____

_____

_____

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 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: _____