

CONFIDENTIAL PATIENT HEALTH HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: *(First MI Last)* _____ Preferred Name: _____

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

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email: _____ Gender: M / F Marital Status: S / M / D / W DOB: _____

Job Status: Not Employed / Employed / Part-time Student / Full-time Student

Occupation: _____ Employer: _____

Who may we thank for referring you to our office? _____

EMERGENCY CONTACT INFORMATION

Name: _____

Primary Care Physician: _____

Phone: _____

Doctor's Office: _____

Relationship: Child / Parent / Spouse / Other: _____

May we send health updates to this physician? Y / N

FINANCIAL INFORMATION

Is today's visit the result of an accident? No / Auto / Work / Other _____

Will we be working with Health Insurance? No / Yes *(Complete Details Below)*

Primary Insurance: _____

Policy Holder: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Secondary Insurance: _____

Policy Holder: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

I authorize payment of medical benefits to McKinnon Chiropractic for any services provided to me or my dependents. I understand I am financially responsible for any amount not covered by my insurance.

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

Patient or Guardian Signature _____ Date _____

Print Name (First MI Last) _____ Date _____

HISTORY OF PRESENT ILLNESS

Major Complaint _____

Secondary Complaint(s) _____

When did this start? _____

How did this start? _____

Grade Intensity/Severity

- None (0/10)
- Mild (1-2/10)
- Mild-Moderate (2-4/10)
- Moderate (4-6/10)
- Moderate-Severe (6-8/10)
- Severe (8-10/10)

Frequency

- Off & On
- Constant

Quality

- Sharp
- Stabbing
- Burning
- Achy
- Dull
- Numb
- Tingling
- Stiff
- Other: _____

Does it radiate?

- No
- Yes _____

Improves with:

- Nothing
- Ice
- Heat
- Movement
- Stretching
- OTC Medications: _____
- Rx Medications: _____
- Other: _____

Worsens with:

- Sitting
- Standing
- Walking
- Lying Down
- Overuse
- Lifting
- Movement
- Changing Positions
- Other: _____

Previous Treatment

- None
- Chiropractor _____
- Medical Doctor _____
- Physical Therapy _____
- ER _____
- Urgent Care _____
- Other: _____

Previous Diagnostic Testing

- None
- X-rays _____
- MRI _____
- CT _____
- Other: _____

*Women: Are you pregnant?

- No Last Menstrual Period: ___ / ___ / ___
- Yes Due Date: ___ / ___ / ___

MEDICAL HISTORY

Have you ever had any of the following? (Please select all that apply.)

Illnesses:

- Asthma
- Autoimmune Disorder (Type) _____
- Blood Clots
- Cancer (Type) _____
- CVA/ TIA (Stroke)
- Diabetes
- Migraine Headaches
- Osteoporosis
- Other: _____

Injuries:

- Back Injury
- Broken Bones
- Head Injury
- Neck Injury
- Falls
- Other: _____

Hospitalizations: (Non-surgical with Date)

- _____
- _____
- _____

Surgeries: (If yes, provide type & surgery date)

- Cancer _____
- Orthopedic
 - Shoulder - L / R _____
 - Elbow/Forearm - L / R _____
 - Wrist/Hand - L / R _____
 - Hip - L / R _____
 - Knee - L / R _____
 - Ankle/Foot - L / R _____
- Spinal
 - Neck: _____
 - Back: _____
- Other: _____

Prescription Medications: None _____

Allergies to Medications: No known drug allergies _____

Print Name (First MI Last) _____ Date _____

FAMILY HISTORY

Does anyone in your IMMEDIATE family have a history of:

- | | |
|---|--|
| <input type="checkbox"/> Aneurysm _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> CVA (Stroke) _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hypertension _____ |

REVIEW OF SYSTEMS

Are you *currently* experiencing any of these symptoms? (Please select all that apply.)

Constitutional: (General)

- Fever
- Fatigue
- None in this Category

Musculoskeletal:

- Joint Pain/Stiffness/Swelling
- Muscle Pain/Stiffness/Spasms
- None in this Category

Neurological:

- Dizziness or Lightheaded
- Convulsions or Seizures
- Tremors
- None in this Category

Psychiatric: (Mind/Stress)

- Nervousness/Anxiety
- Depression
- Sleep Problems
- Memory Loss or Confusion
- None in this Category

Genitourinary:

- Frequent or Painful Urination
- Blood in Urine
- Incontinence or Bed Wetting
- Painful or Irregular Periods
- None in this Category

Gastrointestinal:

- Loss of Appetite
- Blood in Stool or Black Stool
- Nausea or Vomiting
- Abdominal Pain
- Frequent Diarrhea
- Constipation
- None in this Category

Cardiovascular & Heart:

- Chest Pains/Tightness
- Rapid or Heartbeat Changes
- Swelling of Hands, Ankles, or Feet
- None in this Category

Respiratory:

- Difficulty Breathing
- Cough
- None in this Category

Eyes & Vision:

- Eye Pain
- Blurred or Double Vision
- Sensitivity to Light
- None in this Category

Endocrine:

- Infertility
- Recent Weight Change
- Eating Disorder
- None in this Category

Head, Ears, Nose, & Mouth/Throat:

- Frequent or Recurrent Headaches
- Ear - Ache/Ringing/Drainage
- Hearing Loss
- Sensitivity to Loud Noises
- Sinus Problems
- Sore Throat
- None in this Category

Hematologic & Lymphatic:

- Excessive Thirst or Urination
- Cold Extremities
- Swollen Glands
- None in this Category

Integumentary: (Skin, Nails, & Breasts)

- Rash or Itching
- Change in Skin, Hair, or Nails
- Non-healing Sores or Lesions
- Change of Appearance of a Mole
- Breast Pain, Lump, or Discharge
- None in this Category

Allergic/Immunologic:

- Food Allergies
- Environmental Allergies
- None in this Category

I have answered these questions to the best of my knowledge and certify them to be true and correct and I 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 _____

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.

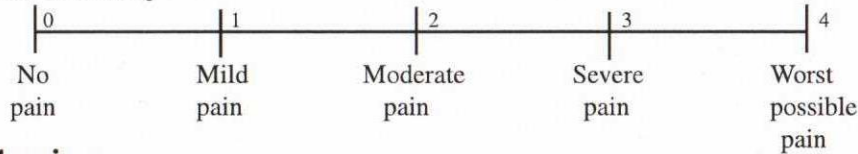
Functional Rating Index

For use with **Neck and/or Back Problems** only.

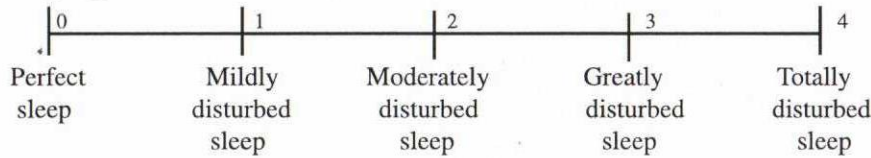
In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

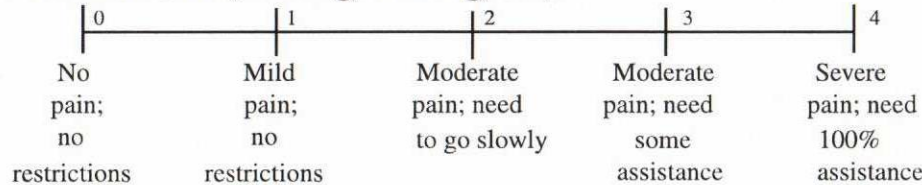
1. Pain Intensity



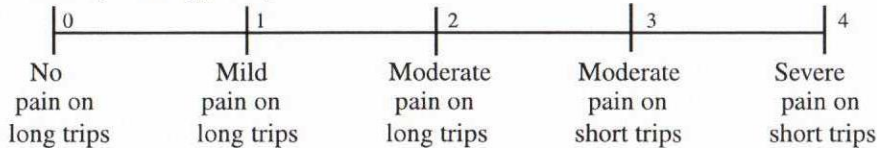
2. Sleeping



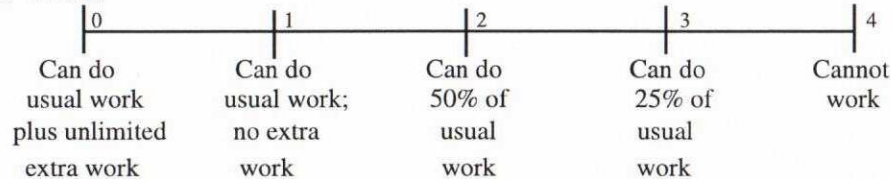
3. Personal Care (washing, dressing, etc.)



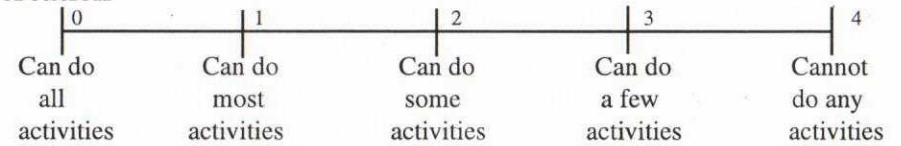
4. Travel (driving, etc.)



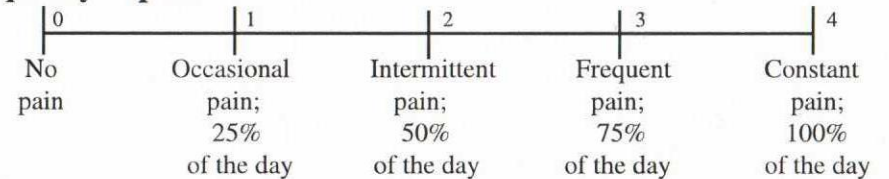
5. Work



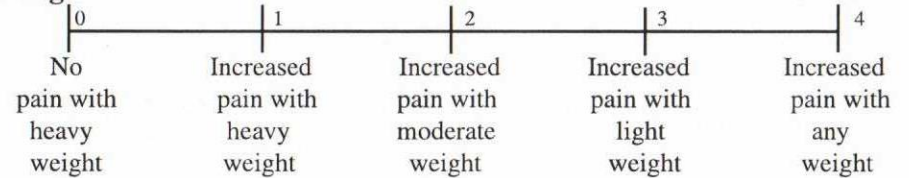
6. Recreation



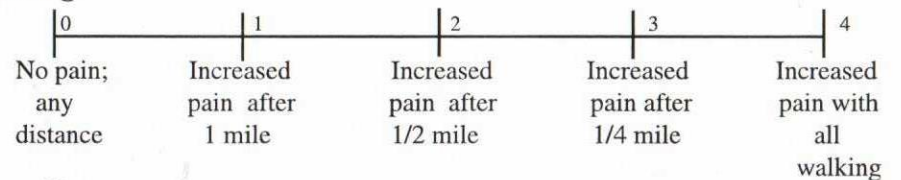
7. Frequency of pain



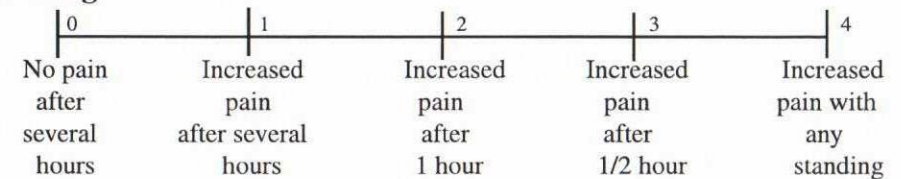
8. Lifting



9. Walking



10. Standing



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

PRINTED

Signature _____

Date _____