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: _____

Phone: _____

Relationship: Child / Parent / Spouse / Other: _____

Primary Care Physician: _____

Doctor's Office: _____

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:

- ❑ Aneurysm _____
- ❑ CVA (Stroke) _____
- ❑ Cancer _____
- ❑ Diabetes _____
- ❑ Heart Disease _____
- ❑ 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 Categl*

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 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.

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