1330 East Arlington Blvd., Suite B • Greenville, NC 27858 • Phone (252) 355-5353

Date: ____ / _____ / 20 ____

Last Name:___________________________ First Name: _______________________Middle Init.: ______

Do you have a preferred name or "nickname"? ☐No ☐Yes: _________________________________

Date of Birth: (mm/dd/year) _______/_______/_________ SSN: _________ — _________ — ________

Address: ____ Apt./Unit #_________________

City: _____________________________ State: _________ Zip: ________________

Home Phone: (______) ______ – ________ Cell Phone: (______) ________ – __________

Email Address: ____

Race/Ethnicity: American Indian Asian Black/African American Hispanic Pacific Islander White Multi-racial Other

Language: (Please Circle One) English Spanish Other: ___________________________

Marital Status: ☐ Single ☐ Married ☐Divorced ☐ Separated ☐ Widowed

Spouse's Name: ____

Emergency Contact Person: ______________________ Emergency Contact Phone: (____) ____ – _____

Preferred Method of Communication: (Circle one) Home Phone Cell phone Email Text message

Your Employer: ____

Your Occupation:____

Work Phone: (____) ______–______ Extension: ________

Family Physician: ____

Address: ______________________________________ Phone: (____) ______–______

How were you referred to our office? (You may choose more than one.) ☐Friend ☐Relative ☐Co-Worker

☐Medical Doctor ☐Yellow Pages ☐Sign ☐Internet Site ☐Dr. McGee/Staff Member

☐Other: ____

Referrer's Name(s): ____

PRIMARY INSURANCE

Policy Holder: ____

Relationship to Patient: _______________ Policy Holder's SSN: ________ — ______ — _______

Policy Holder Date of Birth: ____

Address (if different from above): ____

Policy Holder Employer: _________________________ Phone: (_____) ______ – ______

****

We file primary insurance weekly. We DO NOT file secondary insurance. If you need us to file secondary insurance, we can do so for a $10.00 filing fee.

Are you covered by secondary insurance? □ Yes □ No

How will you be paying for today's visit? □ Cash □ Check □ Credit card □ Debit card

McGee CHIROPRATIC

1330 East Arlington Blvd., Suite B / Greenville, NC 27858 / Ph. (252) 355-5353

Name: ______________________________________ Date: ____ / _____ / 20 ____

Are you a new or returning patient? ☐ New Patient ☐ Returning Patient

Tell us why you are being seen today. ☐Headache ☐Neck Pain ☐Upper Back Pain ☐Low Back Pain Other _______

Note - ♦If you have more than one problem area please describe each of them separately on the next page.♦

Location of your #1, primary problem/pain? _______________Please Specify: ☐ Right ☐ Left ☐ Central

When did your #1 problem/pain start? Onset Date: _____ / _____ / ______ ☐ Not sure when it started.

Was there a specific event that caused the problem/pain? ☐ Yes ☐ No

If yes, describe: ____

What **aggravates** your problem/pain? ☐Lying down ☐Sitting ☐Standing ☐Coughing ☐Sneezing Other: ________

What **reduces** your problem/pain? ☐Lying down ☐Sitting ☐Standing ☐Other: ___________________________

Please describe what you are feeling:

☐Numbness ☐Pins & Needles ☐Burning Pain ☐Aching Pain ☐Stabbing Pain ☐Dull Ache

Does the pain/sensation spread or radiate to other areas? ☐ Yes ☐ No

If yes, please describe: ____

Please rate your pain/problem on a scale from 0 to 10. **0 = No Pain 10 = most severe pain possible**

What is your pain right now?	0	1	2	3	4	5	6	7	8	9	10
What is your pain at its best? (Since your problem started)	0	1	2	3	4	5	6	7	8	9	10
What is your most severe pain since the onset?	0	1	2	3	4	5	6	7	8	9	10
What is your average pain? (Since your problem started)	0	1	2	3	4	5	6	7	8	9	10

Is your problem/pain worse during certain times of the day? ☐ No ☐ Yes Morning Afternoon Evening Nighttime

Have you had similar problems in the past? ☐ Yes ☐ No

Is your problem/pain getting: Worse Better Not Changing

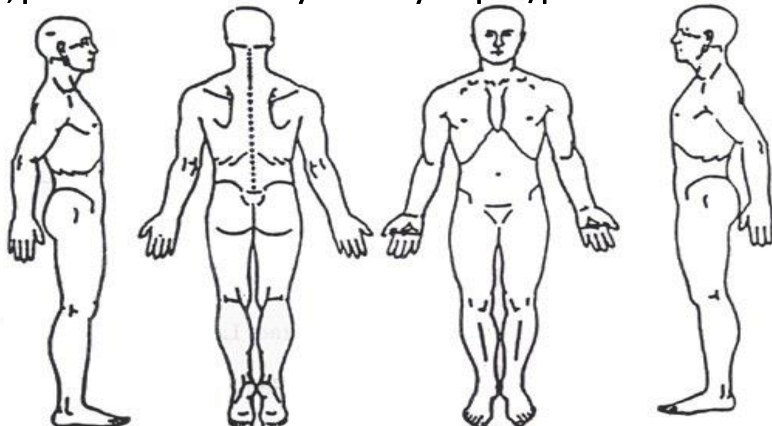
How often do you experience your pain/problem?

☐0-25% of the day ☐25-50% of the day ☐50-75% of the day ☐75-100% of the day

Who have you seen for this problem/pain? ☐No One ☐Chiropractor ☐Medical Doctor ☐Physical Therapy

♦Using the symbols provided, please indicate where you have your pain/problem♦

Stabbing	//////
Aching	△ △ △ △
Stiffness	S S S S S
Burning	X X X X X
Pins & Needles	o o o o
Numbness	= = = = =



Patient Signature: _____________________

Additional History of Present Illness

Complete this form only if you have more than one complaint/problem area.

Name: ____ Date: _____ / ______ / ______

2 What else hurts? What is the next most important problem you would like us to address?

Location of your 2nd problem/pain? ☐Headache ☐Neck Pain ☐Upper Back Pain ☐Low Back Pain Other _____________

Please Specify: ☐ Right side ☐ Left side ☐ Central

When did your 2nd problem/pain start? Onset Date: _____ / _____ / ______ ☐ Not sure when it started.

Was there a specific event that caused the 2nd problem/pain? ☐ yes ☐ no

If yes, describe: ____

What aggravates your 2nd problem/pain? ▫Lying down ▫Sitting ▫Standing ▫Coughing ▫Sneezing Other:__________________

What lessens this problem/pain? ▫Lying down ▫Sitting ▫Standing ▫Coughing ▫Sneezing Other:____________________

Please describe what you are feeling:

☐Numbness ☐Pins & Needles ☐Burning Pain ☐Aching Pain ☐Stabbing Pain ☐Dull Ache

Does the pain/sensation spread or radiate to other areas? ☐ Yes ☐ No

If yes, please describe: ____

Please rate your 2nd pain/problem on a scale from 0 to 10.	**0 = No Pain 10 = most severe pain possible**
What is your pain right now?	0 1 2 3 4 5 6 7 8 9 10
What is your pain at its best? (Since your problem started)	0 1 2 3 4 5 6 7 8 9 10
What is your most severe pain since the onset?	0 1 2 3 4 5 6 7 8 9 10
What is your average pain? (Since your problem started)	0 1 2 3 4 5 6 7 8 9 10

Is this problem/pain worse during certain times of the day? ☐ No ☐ Yes Morning Afternoon Evening Nighttime

Other: ____

Is this problem/pain getting: Worse Better Not Changing

How often do you experience the 2nd pain/problem?

☐0-25% of the day ☐25-50% of the day ☐50-75% of the day ☐75-100% of the day

#3 What else hurts? What is the next most important problem you would like us to address?

Location of your 3rd problem/pain? ☐Headache ☐Neck Pain ☐Upper Back Pain ☐Low Back Pain Other _____________

Please Specify: ☐ Right side ☐ Left side ☐ Central

When did your 3rd problem/pain start? Onset Date: _____ / _____ / ______ ☐ Not sure when it started.

Was there a specific event that caused the 3rd problem/pain? ☐ yes ☐ no

If yes, describe: ____

What aggravates your 3rd problem/pain? ▫Lying down ▫Sitting ▫Standing ▫Coughing ▫Sneezing Other:__________________

What lessens your problem/pain? ▫Lying down ▫Sitting ▫Standing ▫Coughing ▫Sneezing Other:____________________

Please describe what you are feeling:

☐Numbness ☐Pins & Needles ☐Burning Pain ☐Aching Pain ☐Stabbing Pain ☐Dull Ache

Does the pain/sensation spread or radiate to other areas? ☐ Yes ☐ No

If yes, please describe: ____

Please rate your 3rd pain/problem on a scale from 0 to 10.	**0 = No Pain 10 = most severe pain possible**
What is your pain right now?	0 1 2 3 4 5 6 7 8 9 10
What is your pain at its best? (Since your problem started)	0 1 2 3 4 5 6 7 8 9 10
What is your most severe pain since it started?	0 1 2 3 4 5 6 7 8 9 10
What is your average pain? (Since your problem started)	0 1 2 3 4 5 6 7 8 9 10

Is this problem/pain worse during certain times of the day? ☐ No ☐ Yes Morning Afternoon Evening Nighttime

Other: ____

Is this problem/pain getting: Worse Better Not Changing

How often do you experience this 3rd pain/problem?

☐0-25% of the day ☐25-50% of the day ☐50-75% of the day ☐75-100% of the day

Patient Signature:_________________

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Name: ____ Date: ____ / _____ / 20 ____

Other Symptoms:

Do you have any of the following symptoms?

☐ Shortness of breath ☐ Chest pain ☐Fever ☐ Difficulty walking ☐ Dizziness ☐Headache
☐ Recent changes in bowel or bladder habits ☐Joint noises/popping ☐ Muscle incoordination
☐ Unexplained weight gain or weight loss ☐ Muscle weakness ☐ Visual disturbance
☐ Frequent Fatigue ☐ Abdominal pain ☐ None of these

Have you been treated by a physician for any healthcare problem in the past 12 months? ☐Yes ☐No

If yes, describe: ____

-Medical History-

Indicate which of the following illnesses you have now or have had in the past.

Past or Current Conditions

☐Allergies/Sinus
☐Pollen ☐Environmental
☐Cancer ____
____
☐Depression ___________________
☐Diabetes
☐Type I ☐Type II
☐Fibromyalgia __________________
☐Headaches ____________________
☐Heart Disease ☐Pacemaker ☐Defibrillator
☐Pregnancies _______ ☐Currently Pregnant
Blood Thinner Medication? ☐Yes ☐No

Past or Current Conditions

☐Heart Attack ___________________________
☐High Blood Pressure ☐I take medication for this
☐Kidney Stones/Kidney Disease _____________
☐Asthma/Lung Disorder ___________________
☐Stroke ________________________________
☐Hyperthyroid ☐Hypothyroid _____________
☐Ulcers/Stomach _________________________
☐Prostate Condition ______________________
☐HIV __________________________________
Other __________________________________
____

-Surgery-

Please indicate below the types of surgeries you have had. ☐ None

☐Low Back __________________________
☐Neck ____________________________
☐Shoulder R or L ___________________
☐Hip R or L _________________________
☐Knee R or L _______________________
☐Foot/Ankle _______________________
☐Hernia ___________________________
☐Gall Bladder ______________________
☐Heart ____________________________
☐Lung/Chest________________________
☐OB/GYN __________________________
☐Other ____________________________

Medications

Please list all medications you are taking. ☐None

Start date	Name	Dose	For what condition?
________	____________	________	____________
________	____________	________	____________
________	____________	________	____________
________	____________	________	____________

Are you allergic to any medications? ☐ No ☐ Yes: ____
____

Family History

Low Back Pain: Father Mother Sister Brother
Low Back Surgery: Father Mother Sister Brother
Diabetes: Father Mother Sister Brother
Heart Disease: Father Mother Sister Brother
Cancer: Father Mother Sister Brother
Multiple Sclerosis: Father Mother Sister Brother
Arthritis: Father Mother Sister Brother

Social History

Do you smoke? ☐No ☐Yes How much?___pk/day
Exercise regularly? ☐No ☐Yes
Number of hours of sleep per night ____________
Job requires: ☐Sitting/Computer
☐Light Labor ☐Moderate Labor ☐Heavy Labor
☐Repetitive Movements ☐High Stress Job

Patient Signature:____________________

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