McGee CHIROPRACTIC

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: _____ ☐ Full Time Student

Your Occupation:_____ ☐ Part Time Student

Work Phone: (____) _____–_____ Extension: _____

Family Physician: _____

Address: _____ Phone: (____) _____–_____

***Do we have your permission to send office notes to your primary care physician**? ☐ Yes ☐ No

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: (_____) _____ – _____

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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

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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 ☐Stiffness

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

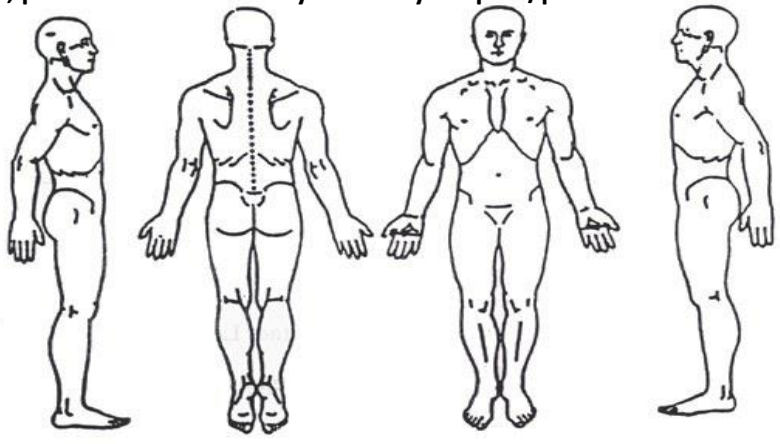
Is your problem/pain getting: ☐Worse ☐Better ☐Not Changing

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

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Patient Signature:_____

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 ☐Other 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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