McCartney Family Chiropractic and Wellness Center
1079 South Baldwin Road
Lake Orion, MI. 48360
248.391.1600

Confidential Patient Information

Personal Information

Name:_____ **Date:** _____/_____/_____
First Middle Last

Address: _____Apt # _____

City: _____ **State:**_____ **Zip:** _____ **Country:**_____

Home Phone: (_____) _____-_____ **ext** _____ **Work Phone:** (_____) _____-_____ **ext** _____

Birth Date: _____ /_____/_____ **Age:**_____ **Sex: Male/Female** **Social Security #:** _____-_____-_____

Email Address: _____

Spouse's Name: _____

Children (Names and Ages): _____

Ethnic Descent or Ancestry: _____

How did you hear about us? ☐**Family/Friend/Co-worker**_____
☐**Internet/website**_____ ☐**Advertisement**_____
☐**Physician**_____ ☐**Other:**_____

Adult Illness(es): **Check all health/past conditions. CIRCLE all CURRENT conditions.**

☐ **ADD**	☐ **cystic kidney disease**	☐ **hypertension**	☐ **scoliosis**
☐ **Alzheimer's**	☐ **depression**	☐ **influenzal pneumonia**	☐ **seizures**
☐ **anemia**	☐ **diabetes (insulin dep)**	☐ **liver disease**	☐ **shingles**
☐ **arthritis**	☐ **diabetes (non insulin)**	☐ **lung disease**	☐ **sleep apnea**
☐ **asthma**	☐ **eczema**	☐ **Lupus erythema**	☐ **STD's (unspecified)**
☐ **cancer**	☐ **emphysema**	☐ **Mononucleosis/Epstein-Barr**	☐ **suicide attempt(s)**
☐ **cerebral palsy**	☐ **eye problems**	☐ **Multiple sclerosis**	☐ **thyroid problems**
☐ **chicken pox**	☐ **fibromyalgia**	☐ **Parkinson's disease**	☐ **vertigo**
☐ **crohn's/colitis**	☐ **heart disease**	☐ **pneumonia**	☐ **yeast, thrush or fungal inf.**
☐ **CRPS (RSD)**	☐ **hepatitis**	☐ **psoriasis**	☐ **other:**_____
☐ **CVA (stroke)**	☐ **HIV**	☐ **psychiatric problems**	☐ **other:**_____

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. ☐ I deny taking any medications.**

Medication	Dosage	For What Condition?	How long have you taken?

Name:_____ Date:_____/_____/_____

Rate each of the following symptoms based on your typical health profile.

Point Scale: 0—*Never or almost never* have the symptom
1—*Occasional*, effect is *not severe* **2—***Occasional*, effect is *severe*
3—*Frequent*, effect is *not severe* **4—***Frequent, effect is severe*

HEAD	_____ Headaches/Migraines _____ Faintness _____ Troubles Sleeping _____ Dizziness **TOTAL:**_____	
EYES	_____ Watery or itchy eyes _____ Swollen, reddened or sticky eyelids _____ Bags or dark circles under eyes _____ Blurred or tunnel vision **TOTAL:**_____	
EARS	_____ Itchy ears _____ Earaches, ear infections _____ Drainage from ear _____ Ringing in ears, hearing loss **TOTAL:**_____	
NOSE	_____Stuffy nose _____Sinus problems _____Hay fever _____Sneezing attacks _____Excessive mucus formation **TOTAL:**_____	
MOUTH/ THROAT	_____ Chronic coughing _____ Gagging, frequent need to clear throat _____ Sore throat, hoarseness, loss of voice _____ Swollen/discolored tongue, gums, lips _____ Canker sores **TOTAL:**_____	
SKIN	_____ Acne _____ Hives, rashes, dry skin _____ Hair loss/increased facial/body hair _____ Flushing, hot flashes _____ Excessive sweating **TOTAL:**_____	
HEART	_____ Chest pain _____ Irregular or skipped heartbeat _____ Rapid or pounding heartbeat **TOTAL:**_____	
LUNGS	_____ Chest congestion _____ Asthma, bronchitis _____ Shortness of breath _____ Difficulty breathing **TOTAL:**_____	
OTHER	_____ Frequent illness _____ Frequent or urgent urination _____ Genital itch or discharge _____Interest in having sex is low/unable _____Urge to urinate several times a night _____Urge to urinate several times a day **TOTAL:**_____	
DIGESTIVE TRACT		_____ Nausea, vomiting _____ Diarrhea _____ Constipation _____ Bloated feeling _____ Belching, passing gas _____ Heartburn _____ Intestinal/stomach pain **TOTAL:**_____
JOINTS/ MUSCLES		_____ Pain or aches in joints _____ Arthritis _____ Stiffness/limitation of movement _____ Feeling of weakness of tiredness _____ Pain or aches in the muscles **TOTAL:**_____
WEIGHT		_____ Binge eating/drinking _____ Craving certain foods _____ Excessive weight _____ Water retention _____ Underweight _____ Compulsive eating **TOTAL:**_____
ENERGY/ ACTIVITY		_____ Fatigue, sluggishness _____ Apathy, lethargy _____ Hyperactivity _____ Restlessness **TOTAL:**_____
MIND		_____ Poor memory _____ Confusion, poor comprehension _____ Difficulty in making decisions _____ Stuttering or stammering _____ Slurred speech _____ Learning disabilities _____ Poor concentration **TOTAL:**_____
EMOTIONS		_____ Mood swings _____ Anxiety, fear, nervousness _____ Anger, irritability, aggressiveness _____ Depression **TOTAL:**_____
Menstruating Women Only		_____Premenstrual Symptoms _____Cramping or pain during period _____Absence of periods _____Periods occur irregular _____Prolonged/heavy flow during period **TOTAL:**_____
All Women		_____ Vaginal dryness _____Sexual intercourse is uncomfortable _____Breast tenderness/soreness **TOTAL:**_____
GRAND TOTAL:		

Name: Date: / /

Surgery (ies): ☐ I deny having any surgical procedures. Write the DATE of the procedure in the blank following.

☐ angioplasty_____	☐ cosmetic_____	☐ hysterectomy_____	☐ pacemaker insertion_____
☐ appendectomy_____	☐ D & C_____	☐ joint reconstruction_____	☐ rotator cuff_____
☐ caesarian section_____	☐ dental surgery_____	☐ joint replacement_____	☐ spinal fusion_____
☐ cardiac catheterization_____	☐ gall bladder_____	☐ knee repair_____	☐ tonsillectomy_____
☐ carpal tunnel repair_____	☐ hemorrhoidectomy_____	☐ laminectomy_____	☐ other:_____
☐ coronary artery bypass_____	☐ hernia repair _____	☐ mastectomy_____	☐ other:_____

ALL Females ONLY: Ob/Gyn

Number of pregnancies: or ☐ N/A	Have you ever been diagnosed with fibroids, cysts, or endo-metriosis? Yes ☐ No ☐ If yes, what:
Number of C-sections: or ☐ N/A	
Number of Miscarriages:	Pain with menses (present or past)?: Yes ☐ No ☐
I ☐ am pregnant. I ☐ am NOT currently pregnant	Has your period skipped (present or past)? Yes ☐ No ☐
Age at 1st period:	How long has it skipped?
How many days is/was your menses (ie 6 days)?	Was there clotting (present or past)?: Yes ☐ No ☐
How many days is/was your current cycle (ie 28 days)?	Would you consider your periods heavy (present or past)?: Yes ☐ No ☐
Start date of last menses?	
Have you ever used hormonal contraception? Yes ☐ No ☐ If yes, when:	What kind of contraception have you used or currently use? ☐ Partner vasectomy ☐ IUD ☐ Diaphragm ☐ Condom ☐ Hormones ☐ Tubal ligation
Hormonal Contraception used or using: ☐ Birth control pills ☐ Patch/Injection ☐ Nuva Ring	
Are you using the pill now? Yes ☐ No ☐ If yes, for how long:	
In the 2nd half of your cycle, do you have or did you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes ☐ No ☐	
Date of last Mammogram: Normal ☐ Abnormal ☐	Last PAP Test: Normal ☐ Abnormal ☐

Woman in Menopause ONLY:

Are you in menopause? ☐ Yes ☐ No	Age at Menopause:
Age at pre-menopause:	
Have you had a hysterectomy? ☐ Yes ☐ No If yes; ☐ Complete (ovaries and uterus) ☐ Partial (uterus only)	
Date of hysterectomy:	
Reason for hysterectomy:	
Do you take: ☐ Estrogen ☐ Ogen ☐ Estrace ☐ Provera ☐ Other: ☐ None	
If you have been on hormone replacement how long have you been taking it?	

Family History: **☐ I deny any family health problems.**

Health problems can be genetic and run in families. Does anyone in your immediate family have/had health problems that affect them? _____

_____

Dental History:

Do you currently have any amalgam, silver, metal, and/or gold fillings? Yes ☐ No ☐

If yes, how many? _____If yes, please list which kinds. _____

If you do not have any fillings, have you had any fillings removed in the last 12 months? Yes ☐ No ☐

Name:_____ Date:_____/_____/_____

Diabetics Only: **☐ I am not diabetic.**

How old were you when you discovered you were diabetic: _____
What is the Highest your blood sugar is WITHOUT medications:_____
What is the Highest your blood sugar is WITH medications:_____
What is the Lowest your blood sugar is WITHOUT medications:_____
What is the Lowest your blood sugar is WITH medication:_____
What is your A1C level?_____ If unsure leave blank.

Personal wellness goals and social history:

1) Please list the 5 major health concerns or health goals in your order of importance:
A. _____

B._____

C._____

D. _____

E. _____

2) When was the last time you were completely healthy? You felt alive? You felt everything was moving in the right direction?_____

3) What do you think happened that caused you to start to feel unhealthy or not 100%? (it could be emotional, it could be physical etc.)_____
_____
_____

4) How often do you have bowel movements? ☐ 2-4x a day ☐ 1x a day ☐ 1 x every other day ☐ Less than e/o day
5) Besides your spouse, your kids, your parents and your job, what do you love, what is your passion, what is the one thing you enjoy the most to do?_____

6) Dietary Habits:

Do you skip meals? ☐ Yes ☐ No
Do you consume coffee or other beverages like energy/diet drinks, or colas daily? ☐ Yes ☐ No
If yes, how many servings per day?_____

Do you have any known food sensitivities? ☐ No ☐ Yes:_____

Is there anything special about your diet that we should know? ☐ Yes ☐ No
If yes please explain?_____

7) Have you ever taken any medications (over the counter or prescribed) continuously for more than 2 weeks? Examples include Tylenol, Nasonex, antidepressants, etc. If yes, <u>when and what</u> type of medication were you taking? (<u>ONLY</u> list medications <u>YOU ARE NOT currently taking</u>)_____
_____
_____

8) How high of a priority is your health on a scale of 1-10, 10 being completely dedicated? _____

9) How would you rate your current health condition on a 1-10 scale: 1=disastrous and 10=great _____

10) What is your ability to make changes in your diet on a scale of 1-10, 10 being completely able? _____

11) What do you consider to be the major causes of stress in your life? (for example — spouse, family, friends, loss of a loved one, work, finances, wedding, legal, commute):_____
Please explain:_____

Name:_____ Date:_____/_____/_____

12) Overall Stress: □ None □ Moderate □ Severe

Family Stress: □ None □ Moderate □ Severe

Job Stress: □None □Moderate □Severe

13) Occupation/Job Title: _____ Work: _____ hrs/week

14) Description of Work:_____

15) Overall Sense of Wellbeing: □ Pleased □ Satisfactory □ Displeased

16) How many hours on average do you sleep per night? _____

How would you rate your quality of sleep? □ Great □ Good □ Fair □ Poor

17) Alcohol: □ Do not drink alcohol □ Social consumption only
□ Drink regularly, quantity of ____glasses, per _____

18) Tobacco: □ Do not use tobacco □ Live with a smoker □ Quit smoking
□ Smoke/ Chew _____ times a day.

19) Exercise: □ Do not formally exercise □ Walk occasionally □ Exercise ____ days per week.

20) Would you consider your current lifestyle (check one) □ healthy or □ unhealthy?

21) How much time have you lost from work or school in the past year due to illness or pain?
□ 0-2 Days □ 3-14 days □ >15 days

Consent to exam/consultation:

1) **I hereby state that the information provided by me is accurate and whole.**
2) **I understand that the consultation/exam process does not establish me as a patient and there is no obligation on part of McCartney Family Chiropractic to care for me as a patient.**
3) **I understand after my exam the doctor may not accept me as a patient.**
4) **I understand the care provided here is not to substitute the care of my medical doctor.**
5) **I have read, understand and accept the terms of the consent to exam/consultation.**

Patient Print Name: _____ Patient's Signature:_____ Date:_____

FOR GUARDIANS ONLY:

Guardian Name Print for Authorizing Care: _____

Guardian Signature of Authorizing Care: _____ Date: _____