McCartney Family Chiropractic and Wellness, P.C.
1079 S. Baldwin Rd., Orion Twp., MI 48360
(248) 391-1600

DATE: ____________________

PATIENT INFORMATION

Name: ____ ☐ M ☐ F Birthdate: ___/___/___Age: _____

Address: ____________________________________ City: _______________________ State: _______ Zip: _____

Social Security Number: _______-_______-_______ ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Spouse's Name: __________________________ Do you have children? ☐ Y ☐ N How Many? _______________

Home #: __________________ Cell #: ____________Carrier_______ Email: ______________________________

Preferred contact method: ☐ Home ☐ Work☐ Cell

How did you hear about us? ____

EMERGENCY CONTACT

Name: _______________________________Relationship: ____________________Phone:__________________

INSURANCE INFORMATION

Insurance Company: ______________________Contract/Enrollee ___________________ Group No.__________

OCCUPATION

Employer Name: ____________________________________Employer Phone No. _________________________

Occupation: ___________________________My job duties include: ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor

PATIENT COMPLAINTS (Please check all that apply)

Current	Past		Current	Past		Current	Past	
☐	☐	Neck pain	☐	☐	Mid back pain M54.6	☐	☐	Feet Numbness☐L / ☐R
☐	☐	Neck Stiffness	☐	☐	Mid back stiffness	☐	☐	Constipation
☐	☐	Headaches	☐	☐	Shoulder pain ☐L / ☐R	☐	☐	Poor circulation
☐	☐	Dizziness	☐	☐	Shoulder tightness ☐L / ☐R	☐	☐	High blood pressure
☐	☐	Head feels heavy	☐	☐	Rib pain ☐L / ☐R	☐	☐	Asthma.
☐	☐	Twitching of face	☐	☐	Pain in side ☐L / ☐R	☐	☐	Loss of balance
☐	☐	Grating in neck	☐	☐	Chest Pain ☐L / ☐R	☐	☐	Loss of taste.
☐	☐	Muscle spasms in neck	☐	☐	Low back pain	☐	☐	Fatigue
☐	☐	Arm pain ☐L/ ☐R	☐	☐	Low back stiffness	☐	☐	Nervousness.
☐	☐	Arm Numbness ☐L / ☐R	☐	☐	Hip pain ☐L / ☐R	☐	☐	Sleeping trouble
☐	☐	Wrist pain ☐L / ☐R	☐	☐	Leg pain ☐L / ☐R	☐	☐	Arthritis.
☐	☐	Hand Numbness ☐L / ☐R	☐	☐	Leg numbness ☐L / ☐R	☐	☐	Painful joints .
☐	☐	Cold Hands☐L / ☐R	☐	☐	Knee pain ☐L / ☐R	☐	☐	Swollen joints.
☐	☐	Pain in ears ☐L / ☐R	☐	☐	Pain in feet ☐L / ☐R	☐	☐	Menstrual irregularity

HISTORY

Are your complaints related to an accident? ☐yes ☐ no   If yes, ☐ work related ☐ auto ☐ other ____________________

Does your pain interfere with your? ☐ Work ☐ Sleep ☐ Daily Routines ☐Recreation

Is it possible that you are pregnant? ☐no ☐yes

Have you ever had any injuries, accidents, or falls *(even if you think you were not hurt at the time)*? ☐ No ☐ Yes, if yes please indicate below.

When? Month_______ Year_______ Type of injury: ____

When? Month_______ Year_______ Type of injury: ____

When? Month_______ Year_______ Type of injury: ____

Please indicate what treatment/testing you have already received for these complaints

☐ Chiropractic ☐ Physical Therapy ☐ Medications ☐ Surgery ☐ MRI ☐ CT Scan ☐ None

☐ Other ____

Please indicate which doctors you have already seen for these complaints

Doctor: ____ Phone No. ______________________________

Doctor: ____ Phone No. ______________________________

Doctor: ____ Phone No. ______________________________

SURGERIES

Surgery	Month/Year	Surgery	Month/Year
____________________________	__________	____________________________	__________
____________________________	__________	____________________________	__________
____________________________	__________	____________________________	__________

Have you had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Anemia	☐	☐	Anxiety
☐	☐	Bleeding disorders	☐	☐	Cancer	☐	☐	Chemical dependency
☐	☐	Depression	☐	☐	Diabetes	☐	☐	Epilepsy/Siezures
☐	☐	Fractures	☐	☐	Heart disease	☐	☐	Hepatitis
☐	☐	Hernia	☐	☐	Herniated disc	☐	☐	High cholesterol
☐	☐	Multiple sclerosis	☐	☐	Osteoporosis	☐	☐	Pacemaker
☐	☐	Parkinson's disease	☐	☐	Polio	☐	☐	Prostate problems
☐	☐	Prosthesis	☐	☐	Psychiatric care	☐	☐	Stroke
☐	☐	Suicide attempt	☐	☐	Thyroid problems	☐	☐	Tumors
☐	☐	Ulcers	☐	☐	Other ______________________________			

MEDICATIONS, VITAMINS, AND SUPPLEMENTS

Medication	Dosage	Vitamin/Supplement	Dosage
______________________________	__________	_____________________________	__________
______________________________	__________	_____________________________	__________
______________________________	__________	_____________________________	__________

ALLERGIES

Are you allergic to anything? ☐ No ☐ Yes (if "YES" please list any and all allergies)

____
____
____

SOCIAL

My exercise level is: ☐ Intense ☐ Moderate ☐ Light ☐ Minimal ☐ None

My habits include: ☐ Smoking/Tobacco use _______packs/day ☐ Alcohol _______drinks/week

☐Coffee __________cups/day☐ Soda Pop __________cups/day ☐ Tea __________cups/day

☐ Recreational drug use☐Other ____

What goals would you like us to help you achieve? For example: pain management, increased movement, ability to lift, improved gait, ability to perform during sports, hobbies, or work, weight loss/diet/nutrition, etc.…

____
____

FAMILY

Please mark the conditions that relate to your parents, siblings, or grandparents.

	Diabetes	Heart Disease	Cancer	Stroke	Thyroid	Arthritis	Mental Illness	Auto Immune	Back/ Spine	High Blood Pressure	Osteoporosis	High cholesterol
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother(s) # of: _______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister(s) # of: _______	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother (maternal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather (maternal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother (fraternal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

SUBJECTIVE FINDINGS *PAIN CLASSIFICATION*

CERVICAL: ☐ Mild ☐ Moderate ☐ Severe ☐ Sharp ☐ Dull ☐ Aching ☐ Intermittent ☐ Constant
THORACIC ☐ Mild ☐ Moderate ☐ Severe ☐ Sharp ☐ Dull ☐ Aching ☐ Intermittent ☐ Constant
LUMBAR: ☐ Mild ☐ Moderate ☐ Severe ☐ Sharp ☐ Dull ☐ Aching ☐ Intermittent ☐ Constant
PELVIC: ☐ Mild ☐ Moderate ☐ Severe ☐ Sharp ☐ Dull ☐ Aching ☐ Intermittent ☐ Constant

OBJECTIVE FINDINGS

CERVICAL: Muscle Spasms ☐ L ☐ R ☐ Fixations ______
THORACIC: Muscle Spasms ☐ L ☐ R ☐ Fixations ______
LUMBAR: Muscle Spasms ☐ L ☐ R ☐ Fixations ______
PELVIS: Muscle Spasms ☐ L ☐ R ☐ Fixations ______

RANGE OF MOTION	CERVICAL				LUMBAR			
	+	-	RESULT	NORM	+	-	RESULT	NORM
Flexion				45				90
Extension				45				30
Lateral Flexion				45R				30R
Lateral Flexion				45L				30L
Rotation				80R				30R
Rotation				80L				30L

AREAS OF TENDERNESS

CERVICAL: ☐ L ☐ R _______
DORSAL: ☐ L ☐ R _______
LUMBAR: ☐ L ☐ R _______
PELVIC: ☐ L ☐ R_ _______

POSTURAL DISTORTION

HEAD TILT: ☐ L ☐ R
Shoulder High On: ☐ L ☐ R
Ilium High On: ☐ L ☐ R
Forward Head Carriage: ☐ Y ☐ N 0

Absent 0 Hypoactive 1+ Normal 2+ Hyperactive 4+ Hyperactive 5+

Biceps____L ______ R______ C5, 6, Musculocutaneous N
Brachioradialis____L ______ R______ C6
Triceps L ______ R ______ C6, 7 8, Radial N.
Patellar L ______ R ______ L2, 3, 4, Femoral N.
Achilles L ______ R ______ S1, 2, Tibial N.

ORTHOPEDIC TESTS

Test	L R N			
Foraminal Compression	☐☐☐	At ☐	1L ☐	
Shoulder Depression	☐☐☐	Ax ☐	2 ☐	
Cervical Syndrome	☐☐☐	3 ☐	3 ☐	
Supine Leg Check	☐☐☐	4 ☐	4 ☐	
Soto-Hall	☐☐☐	5 ☐	5 ☐	
Minor's Sign	☐☐☐	6 ☐		
Bechterew's Test	☐☐☐	7 ☐	**L. Ilium**	
Kemp's	☐☐☐	1D ☐	PI ☐	
Lindner's	☐☐☐	2 ☐	As ☐	
Braggard's	☐☐☐	3 ☐	In ☐	
Bilateral Leg lower/raise	☐☐☐	4 ☐	Ex ☐	
Heel and Toe Test	☐☐☐	5 ☐		
Nachla's Test	☐☐☐	6 ☐	**R. Ilium**	
Ely's Test	☐☐☐	7 ☐		
Hibbs	☐☐☐	8 ☐	PI ☐	
Fabere-Patrick	☐☐☐	9 ☐	As ☐	
Gaenslen's Test	☐☐☐	10 ☐	In ☐	
Lasegue's ______ L ______R	☐☐☐	11 ☐	Ex ☐	
			12 ☐	
Apley's Scratch Test (shoulder)	☐☐☐			
Apley'sAprehension (knee)	☐☐☐			

X-RAY REPORT & SPINAL ANALYSIS

Osteophytic Changes C ☐ T ☐ L ☐
Dengeneration C ☐ T ☐ L ☐
Loss of Lordotic Curve C ☐ L ☐
Spina Bifida
Sacralization L ☐ R ☐
Lumbarization L ☐ R ☐
Neuroforaminal Stenosis C ☐ L ☐

Scoliosis (Lateral Curve)
Cervical ☐ L ☐ R
Thoracic ☐ L ☐ R
Lumbar ☐ L ☐ R

Spondylolisthesis Grade ______________
Retrolisthesis Grade ______________
Compression Fracture
Osteoporosis
☐ mild ☐ moderate ☐ severe

Spinal Fusion
☐ congenital ☐ surgical

Ht. _______ Wt _______BloodPressure _______ Ambulatory ☐ Yes ☐ No Antalgia ☐ Yes ☐ No

A	B	C	D
E	F	G	H
I	J	K	L

Special Instructions:

CORRECTIVE CARE PLAN

☐ Daily visits for _______________ weeks
☐ 3 visits per week for __________ weeks
☐ 2 visits per week for __________ weeks
☐ 1 visit per week for ___________ weeks
☐ 1 visit every 2 weeks ☐ 1 visit per month

M T W TH F SA SU

☐ Spinal Manipulation
☐ Traction
☐ Ice ☐ Heat
☐ Spinal Decompression

☐ Laser
☐ Massage
☐ Exercises

Doctor Signature____**Date**_____________