

Welcome To McVady Family Chiropractic

First Name _____ MI _____ Last _____ Birth Date ____/____/____ Age _____ Today's date ____/____/____
 Address _____ City _____ State _____ Zip _____
 Home # () _____ Work # () _____ Ext. _____ Soc. Sec. # _____ - _____ - _____
 Fax # () _____ Cellular # () _____ E-mail Address _____
 ___ Male ___ Female # of Children _____ Single Married Significant Other Widowed Separated Divorced
 Employer _____ Occupation _____ **WOMEN ONLY: Are you pregnant? No ___ Yes ___**
 Name of Spouse (Parent if patient is under 18) _____ Birth Date of Spouse (Parent if patient is under 18) _____
 Whom may we thank for referring you to our office? _____ Method of payment for First Visit: *Cash Check CC*

Your Health Profile

***FOR PRESENT CONDITIONS MARK "P", PAST CONDITIONS MARK "X" (3 MONTHS OR LONGER) (Please 'Circle' if necessary to be more specific)

- | | | |
|---|---|--|
| ___ Numbness/Tingling/Pain in (Arms / hands/ fingers)
R / L Both
___ Headaches/Migraines
___ Fractured Bones
___ Swollen Painful Joints
___ Anemia
___ Pain w/ Cough / Sneeze
___ Heart Problems
___ Prostate Problems
___ Dizziness/Vertigo
___ Fatigue
___ Colon Trouble
___ Cold feet
___ Foot Problems
___ Cold Sweats
___ High Blood pressure
___ Other _____ | ___ Hip Pain R / L
___ Arthritis
___ Convulsions/Epilepsy
___ Tremors
___ Chest Pain
___ Stroke
___ Kidney Trouble
___ Buzzing/Ringing in ears
___ Depression
___ Sleeping Problems
___ Bed Wetting
___ Shortness of Breath
___ Light Bothers Eyes
___ PMS
___ Thyroid Problems | ___ Numbness, Tingling or Pain in (Buttocks/Thighs/Legs/Feet/Toes)
R / L Both
___ Neck Stiffness/ Pain
___ Frequent Colds / Flu
___ Skin Problems
___ Blurred Vision R / L
___ Lung Problems
___ Gall Bladder Problems
___ Loss of Smell
___ Sinus Problems
___ Irritability/Mood Swings
___ Cold Hands
___ Recurring Infection
___ Hot Flashes
___ Problems Urinating
___ Menopause
___ Allergies |
| | | ___ Back Stiffness/Pain
___ Diabetes
___ Asthma/Emphysema
___ Double Vision R / L
___ Loss of Taste
___ Digestive Problems
___ Loss of Balance
___ Nervousness/Anxiety
___ Tension/Stress
___ Stomach Upset
___ Diarrhea/Constip./Gas
___ Jaw/TMJ Problems
___ Heartburn/Reflux
___ Ulcers
___ Cancer (Type) _____ |

Additional Explanation: _____

Have you ever been to a chiropractor before? Y / N When was your last adjustment? _____

Current Health Condition

Chief Complaint (why you are here today): _____

When did this condition begin? _____ Has it ever occurred before: Yes No
 Was this due to an accident/Trauma? Yes No
 If Yes, explain.(ex. fall, auto, sports,) _____

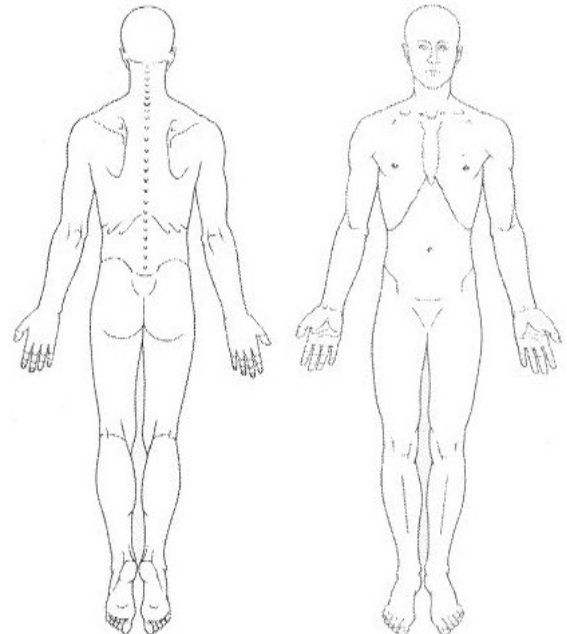
Symptoms: When this problem is at its worst, can you explain in your words how exactly it feels? _____

Severity Mild Moderate Severe
 Does this pain travel or radiate? If so, Where? _____

Quality: (mark all that apply)
 Burning Diffuse Dull/Aching Localized
 Sharp Shooting Stabbing Tingling
 Radiating Other _____

Is there anything that makes this better or worse? _____

Please mark on the diagram below the area of discomfort ▼



Patient Name: _____ Date: _____

Timing:

- Worse AM Worse PM Worse W/ Activity Worse Sleeping
- Occasional (0-25%) Intermittent (25-50%) Frequent (50-75%) Constant (75-100%)

How often do you find yourself suffering from this problem? _____

How long does the problem last? (all the details of timing) _____

What solutions have you attempted to solve this problem? _____

Daily Activities: Effects of Current Condition on Performance

Carrying Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Changing Positions	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading/Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Self Care – Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Self Care – Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Self Care – Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting Still	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing Still	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Please List any effects that this may have on any Recreational Activities: _____

Are there any other complaints/conditions that the doctor should address? If so, list and describe: _____

Medications: What medications are you currently taking and for what conditions?

Is there anything else you think the doctor should know concerning your condition? Yes _____ No _____

On a scale of 1-10, ten being the highest, rate your commitment to correcting the problem? _____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation and consent to recommended treatments.

Signature

____/____/____
Date

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore begin my chiropractic examination and any other further care on this basis.

(Signature)

(Date)

McVady Family Chiropractic
8128 W. 143rd Street, Orland Park, IL 60462
(708) 226-1161

McVady Family Chiropractic

PATIENT ACKNOWLEDGEMENT

For use and/or disclosure of Protected Health Information (PHI) To carry out Treatment, Payment and Healthcare Operations

_____, hereby state that by signing this Consent I acknowledge and agree as follows:
(Print Name)

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The Practice's "Notice of Privacy Practices" is also provided in the reception area display table and on the Practice's website at www.mcvady.com. I may also request a copy from this office at any time via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)	Date Signed	Signature of Individual
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Signature of Legal Representative	Date Signed	Relationship
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Witness (Office Personnel)	Date Signed
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For Doctor's Use Only
Please Do Not Write On This Page

Bio-structural Examination

Patient Name: _____ Date _____

Leg Checks:

Prone	L	R	¼	½	¾	1
Pelvic	Pos	Neg	NF			
Cerv. Syn.	L	R	BiLateral			
Sac. Restrict.	L	R	BiLateral			

Palpation:

C: 1 2 3 4 5 6 7 T: 1 2 3 4 5 6 7 8 9 10 11 12 L: 1 2 3 4 5 S

Static: _____

Motion: _____

Muscle: _____

Leg Checks:

Supine	L	R	¼	½	¾	1
SLR	L	R	(P)	Location:	_____	

ROM:

Cervical	Extension			(P)	Level	_____
	Flexion			(P)	Level	_____
	Rotation	L	R	(P)	Level	_____
	Lat. Flex	L	R	(P)	Level	_____
Lumbar	Extension			(P)	Level	_____
	Flexion			(P)	Level	_____
	Rotation	L	R	(P)	Level	_____
	Lat. Flex	L	R	(P)	Level	_____

Posture:

Hd Tilt	L	R	Bal.	AHC
Shldr. Inf.	L	R	Bal.	
Pelvis Inf.	L	R	Bal	
Bi-Lat Wtg.	L ____	R ____	Bal	

Ortho/Neuro Findings: _____

Additional Comments: _____
