



# WELCOME TO DR. PETER McPARTLANDS CHIROPRACTIC OFFICE

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

THANK YOU.

Name \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Number of Children \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_  
 (Indicate if child, student, housewife, unemployed, retired)

Social Business Company  
 Sec # \_\_\_\_\_ Phone \_\_\_\_\_ Name \_\_\_\_\_ Location \_\_\_\_\_

Spouse's Spouse's Spouse's  
 First Name \_\_\_\_\_ Soc. Sec # \_\_\_\_\_ Employer \_\_\_\_\_ Location \_\_\_\_\_

## HEALTH INFORMATION

Have you had previous chiropractic care? \_\_\_\_\_

What is your major complaint? \_\_\_\_\_  
 \_\_\_\_\_

Other complaints: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had this or similar conditions in the past? \_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_

Is this condition getting progressively worse? Yes  No  Constant  Comes and goes

Is this condition interfering with your: Work  Sleep  Daily Routine  Other \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

Other doctors who treated this condition \_\_\_\_\_  
 \_\_\_\_\_

List surgical operations and years \_\_\_\_\_  
 \_\_\_\_\_

Drugs you now take  Nerve pills  Pain killers  Muscle relaxers  "Pep" pills  Tranquilizers  
 Insulin  Birth control pills  Others \_\_\_\_\_

Ages of mattress \_\_\_\_\_  Comfortable  Uncomfortable

Are you wearing:  Heel lifts  Sole lifts  Inner soles  Arch supports

Have you been in an auto accident?  Past year  Past 5 years  Over 5 years  Never

Describe: \_\_\_\_\_

Have you had any other personal injury or accident?  Past year  Past 5 years  Over 5 years  
 None

Describe: \_\_\_\_\_

# WORKERS COMPENSATION QUESTIONNAIRE

(IF APPLICABLE)

Please explain in detail how your accident happened \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who should we contact at place of employment? \_\_\_\_\_

Supervisor's name \_\_\_\_\_ Has report been filed? \_\_\_\_\_

Give time and date and location present injury occurred \_\_\_\_\_  AM  PM \_\_\_\_\_ 19 \_\_\_\_\_

Where did you feel pain immediately after the accident? \_\_\_\_\_

Did you return to work?  Yes  No If so, date returned to work \_\_\_\_\_

Have you ever injured this area before?  Yes  No if so, when? \_\_\_\_\_

If injured before, did you lose time from work?  Yes  No

If you lost time from work with injuries prior to this injury, give name of doctor or doctors consulted \_\_\_\_\_

Do any other diseases or accidents affect your employment?  Yes  No If so, explain \_\_\_\_\_  
\_\_\_\_\_

Do you have a history of absenteeism caused from accidents on the job?  Yes  No

Have you ever had a Workmen's Compensation claim before?  Yes  No

Before the injury were you capable of working on an equal basis with others your age?  Yes  No

Are your work activities restricted as a result of this accident?  Yes  No

Since this injury are your symptoms  improving?  getting worse?  the same?

# AUTO ACCIDENT QUESTIONNAIRE

(IF APPLICABLE)

Please explain in detail how your accident happened \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_ Claim No. \_\_\_\_\_

Driver of other vehicle (if any) \_\_\_\_\_ Insurance \_\_\_\_\_

Name \_\_\_\_\_ Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Driver of vehicle in which you were injured (if applicable) \_\_\_\_\_ Insurance \_\_\_\_\_

Name \_\_\_\_\_ Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Name of your insurance adjustor \_\_\_\_\_

You were heading  North  East  South  West on \_\_\_\_\_ (street or highway)

Other vehicle was headed  North  East  South  West on \_\_\_\_\_ (street or highway)

Were police notified?  Yes  No

Were you knocked unconscious?  Yes  No If so, for how long? \_\_\_\_\_

You were struck from  Behind  Front  Left side  Right side

You were  Driver  Passenger  Front seat  Back seat  Using seat belts  Other protective devised

What were the time and date of present injury? \_\_\_\_\_

Where did you feel pain immediately after the accident? \_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

Have you ever had any complaints in the involved area before?  Yes  No

If so, what were the complaints? \_\_\_\_\_

Before the injury were you capable of working on an equal basis with others your age?  Yes  No

Are your work activities restricted as a result of this accident?  Yes  No

Since this injury are your symptoms  Improving?  Getting worse?  Same?

# HEALTH HISTORY:

Please indicate for each of the questions below your experience by use of the following codes: 1—previously had; 2—presently have.

## MUSCULO-SKELETAL SYSTEM

- Low back problems
- Pain between shoulders
- Neck problems
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Ruptures
- Broken bones

### SMOKER

- Yes  No

## GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scantly urination
- Painful urination
- Discolored urine

### FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on breast
- Are you pregnant
- Yes  No

## GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting food
- Vomiting blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

## CARDIO-VASCULAR-RESPIRATORY

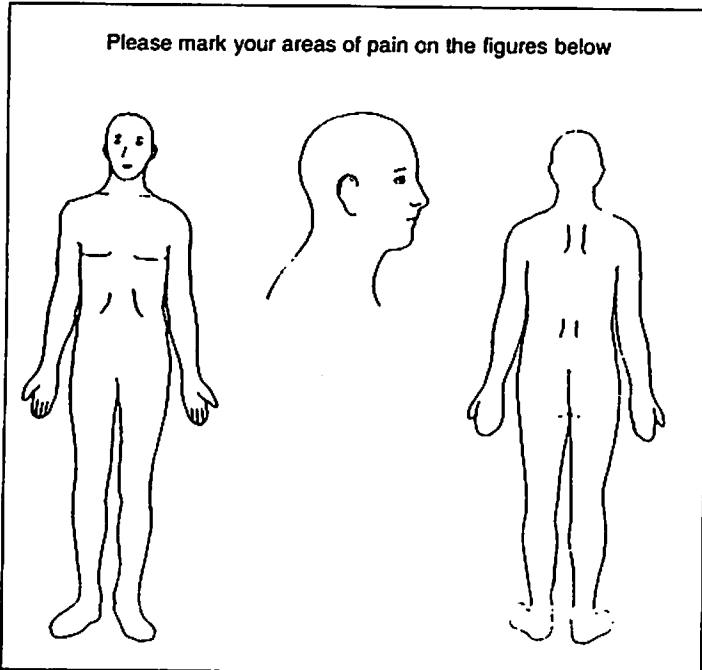
- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose Veins

## EYE, EAR, NOSE, AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear Discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing thru nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech

## NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscle jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression



**FAMILY HEALTH INFORMATION:** (Many health problems are the result of hereditary spinal weaknesses, thus information about your family members will give us a better picture of your total health.)

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

**INSURANCE INFORMATION:**

Is your condition due to an auto accident or job related injury?  Yes  No

Do you have Health Insurance?  Yes  No If yes,

Insured's Name (If Not Patient) \_\_\_\_\_ Phone: \_\_\_\_\_

Policyholder (i.e., Employer) \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Examiner or Agent: \_\_\_\_\_

Claim No.: \_\_\_\_\_ Policy No.: \_\_\_\_\_ If accident, Date: \_\_\_\_\_

Attorney's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Are you covered by Medicare?  Yes  No

**AUTHORIZATION TO PAY PHYSICIAN**

I hereby authorize the \_\_\_\_\_ Insurance Company to pay by check made out and mailed directly to Dr. Peter McPartland the medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services Rendered. This payment will not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

**OFFICE POLICY**

I understand and agree that health and accident policies are an arrangement between an Insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the Insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I also understand that notice is required on all cancellations, and that otherwise there will be a fee for missed appointments.

Patient's Signature \_\_\_\_\_

Guardian or Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This is to certify that to the best of my knowledge I am not pregnant and Dr. Peter McPartland or Staff has my permission to take x-rays of me.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby give my consent to Dr. Peter McPartland to examine, x-ray and treat my child or ward

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_