PATIENT INTRODUCTION CARD

McCauley Chiropractic

Today's Date:_____/_____/_____

Last Name: _____**First Name:** _____**MI:** _____

Street: _____ City: _____ State: _____Zip_____

Home Phone #: (_____)_____ Cell/Work #: (_____)_____

Birth Date:_____/_____/_____ □ Male □ Female SS# _____-_____-_____

□ Employed / Occupation: _____ □ Full-Time Student □ Part-Time Student

Email:_____ Marital Status: □ Single □ Married □ Other

Number of Children/ Ages: _____ Spouses Name: _____

Whom may we thank for referring you? _____

Briefly describe the reason for your visit: _____

_____

DO YOU HAVE ANY DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK.

□Headaches	□Pain in Hand or Arms	□Chest Pains
□Neck Pain	□Numbness in Hands or Arms	□Heart Attack
□Sleeping Problems	□Pain in Legs or Feet	□High Blood Pressure
□Low Back Pain	□Numbness in Legs or Feet	□Stroke
□Nervousness	□Fatigue	□Cancer
□Tension	□Depression	□Painful Urination
□Irritability	□Lights Bother Eyes	□Diabetes
□Dizziness	□Loss of Memory	□Diarrhea
□Pain Between Shoulders	□Shoulder Pain	□Constipation
□Stiff Neck	□Sinus	□Stomach Upset
□Joint swelling	□Shortness of Breath	□Heartburn/Reflux
□Fever	□Asthma	□Weight Loss
□Loss of Balance	□Allergies	□Loss of Smell or Taste
□Ringing in Ears	□Cold Hands	□Menstrual Cramps
□Jaw/TMJ Problems	□Cold Feet	□Menopause

Have you ever been treated by a chiropractor before □ Yes □ No

If so, whom, and please explain: _____

Is this condition due to an accident? □Yes, Date:_____ □No What Type: □ Auto □ Work □ Home □ Other

To whom, have you made a report of your accident? □ Auto Insurance □ Employer □ Worker Comp □ Other

Do you have health insurance? □Yes □No What Company? _____

In case of Emergency, who should we contact? Name/Number:_____

NAME _____ ***ID#*** _____ ***DATE*** _____

When did the symptoms **BEGIN?:** ☐ UNKNOWN ☐ GRADUAL ☐ SUDDEN ☐ ACCIDENT ☐ AUTO ☐ WORK

How Long have you had your **SYMPTOMS?:** ☐ PAST FEW DAYS ☐ PAST WEEK OR SO ☐ PAST MONTH ☐ PAST FEW MONTHS ☐ PAST YEAR ☐ PAST FEW YEARS ☐ PAST YEARS +

Are your **SYMPTOMS?:** ☐ NO CHANGE ☐ GETTING WORSE ☐ MUCH WORSE ☐ SOME BETTER ☐ MUCH BETTER

How bad does it hurt? *Please circle one* **(no pain)** 0 1 2 3 4 5 6 7 8 9 10 **(worst pain imaginable)**

Pain is **WORSE:**

☐ MORNING ☐ EVENING ☐ AFTERNOON ☐ THROUGHOUT THE NIGHT

MADE WORSE WHEN:

☐ EXERCISES	☐ SITTING	☐ WHILE RUNNING
☐ BEND/TWISTING	☐ STANDING	☐ WORKING
☐ WEATHER	☐ LYING DOWN	☐ WHILE SLEEPING
☐ DRIVING CAR	☐ WHILE WALKING	☐ AFTER ACTIVITY

Pain is **BEST:**

☐ MORNING ☐ EVENING ☐ AFTERNOON ☐ THROUGHOUT THE NIGHT

MADE BETTER WHEN:

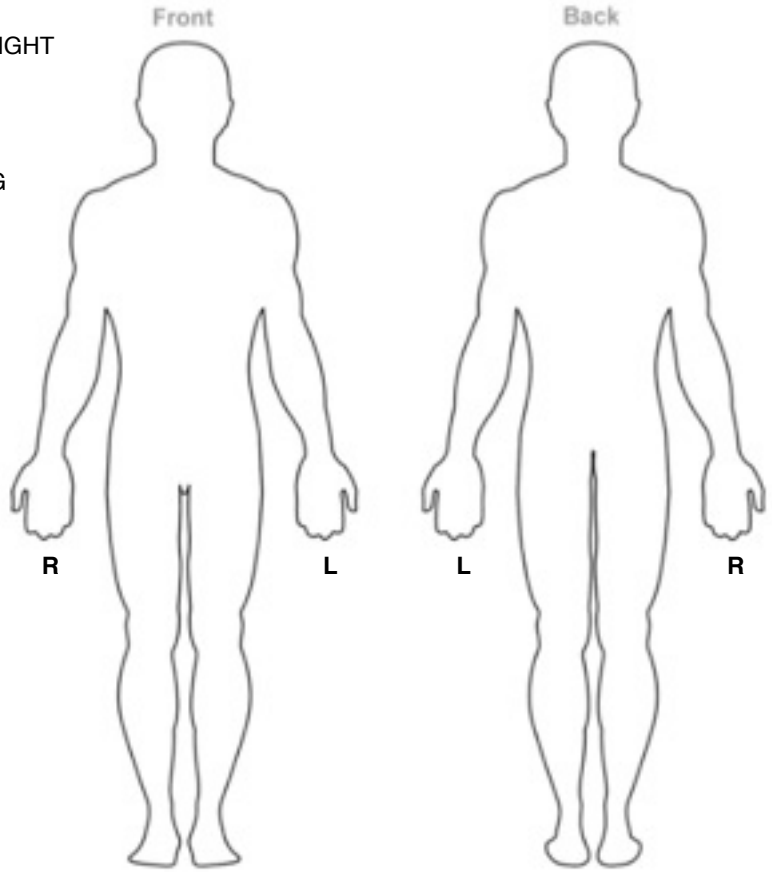
☐ EXERCISES	☐ SITTING	☐ WHILE RUNNING
☐ BEND/TWISTING	☐ STANDING	☐ WORKING
☐ WEATHER	☐ LYING DOWN	☐ WHILE SLEEPING
☐ DRIVING CAR	☐ WHILE WALKING	☐ AFTER ACTIVITY

FREQUENCY:

- ☐ RARELY (1%-10%)
- ☐ OCCASIONAL (11%-25%)
- ☐ INTERMITTENT (26%-50%)
- ☐ FREQUENT (51%-75%)
- ☐ PERSISTENT (76%-99%)
- ☐ CONSTANT (100%)

DESCRIPTION of your pain or symptoms:

☐ THROBBING	☐ TENDER
☐ SHOOTING	☐ TIRING
☐ SHARP	☐ DULL
☐ STABBING	☐ SPREADING
☐ PINCHING	☐ IRRITATING
☐ ACHING	☐ INTENSE
☐ BURNING/HOT	☐ RADIATING
☐ STINGING	☐ TIGHT
☐ TINGLING	☐ COOL/COLD



PLEASE MARK WHERE YOUR PAIN IS LOCATED AND RADIATES TO

YOUR CHIEF COMPLAINT IS:

☐ MILDLY ☐ SLIGHTLY ☐ MODERATELY ☐ SEVERELY

AFFECTED DOING THE FOLLOWING:

☐ SITTING	☐ BATHING	☐ USING STAIRS
☐ STANDING	☐ TOILET USE	☐ LAUNDRY
☐ GROOMING	☐ IN/OUT OF BED	☐ HOUSEKEEPING
☐ DRESSING	☐ IN/OUT OF CAR	☐ SHOPPING
☐ EATING	☐ MEAL PREP	☐ USING PHONE

PREVIOUS CARE FOR YOUR CURRENT COMPLAINT:

☐ CHIROPRACTOR ☐ MASSAGE ☐ MEDICAL DOCTOR ☐ E.R. ☐ ORTHOPEDIST ☐ NEUROLOGIST ☐ FAMILY DOCTOR
☐ PHYS.THERAPY ☐ ACUPUNCTURE ☐ BED REST ☐ MRI ☐ CT-SCAN ☐ SURGERY ☐ RX. PAIN KILLERS ☐ OTC PAIN MEDS
☐ COLD PACKS ☐ HOT PACKS ☐ SPINAL SURGERY ☐ SPINAL FUSION ☐ INJECTIONS ☐ MUSCLE RELAXANTS

PATIENTS/GUARDIANS SIGNATURE: _____ **DATE:** _____