PERRIER KINESIOLOGY | McGEE KINESIOLOGY

Leaders ins Muscle and Joint Performance

214 S. Rock Rd, Suite 103 Wichita, KS 67207
(316) 687-5362 (MUSLDOC)
www.musldoc.com

PATIENT DATA SHEET

Name:_____
Married_☐_Single_☐_Divorced_☐_Widowed_☐
Spouse Name:_____

Address _____
City_____State____Zip_____
Primary Phone (_____)_____
Home Phone (_____)_____
Work Phone (_____)_____

E-Mail Address_____
Birth Date_____/_____/_____ Age_____
S.S. #_____-_____-_____
Family Members_____
Employment_____
Title_____
Work Duties_____

Referred to our office by:_____

Responsible Party or Insured: (if different)
Self_☐_Spouse_☐_Parent_☐_
Name:_____
Address_____
City_____State____Zip_____

Primary Phone (_____)_____
Home Phone (_____)_____
Work Phone (_____)_____

E-Mail Address_____
Birth Date_____/_____/_____ Age_____
S.S. #_____-_____-_____
Insurance Company Name_____
Employment_____
Title_____
Name of Emergency Contact_____
Phone (_____)_____

MEDICAL HISTORY

Did you have any unusual birth or pre-birth circumstances? (difficult delivery, forceps, etc.) _____
_____

Childhood diseases: Measles☐ Mumps☐ Chicken Pox☐ Other_____
Most recent vaccination for: DPT_____ Polio_____ MMR_____ Tetanus_____ Other_____
Unusual childhood diseases:_____

List any surgeries you have had **Date** **Residual Symptoms**
1._____
2._____
3._____

Accidents/falls you have ever had (include work/auto) **Date** **Residual Symptoms**
1._____
2._____
3._____
4._____

Have you ever had any fractures? **Date** **Residual Symptoms**
1._____
2._____
3._____

Adult illnesses or conditions:_____
_____

What is your general state of health? (circle one) ☐Excellent ☐Good ☐Fair ☐Poor

When was the last time you really felt good? ____Weeks ____Months ____Years

Current Height:_____
Current Weight:_____

Any Chance you are pregnant? _____ If no, when was your last menstrual cycle? _____

Date of last chiropractic treatment_____
Name & location of chiropractic doctor:
_____
_____
Type of treatment_____
Total time under care_____

Date of last physical exam_____
What prompted the exam_____
_____
Date of last complete lab work_____
Date of most recent x-rays_____
Parts of the body x-rayed_____

Name of medical physician_____Phone_____

Do you currently take: (to help the doctor, please note type of medication and how much you take along with how long you have taken them)

1. Vitamins/supplements/herbs_____
2. Birth control pills_____
3. Over the counter drugs_____
4. Sedatives/tranquilizers_____
5. Pain killers/ muscle relaxers_____
6. Blood pressure medicine_____
7. Insulin_____
8. Laxatives_____
9. Recreational drugs_____
10. Other_____

How often do you use:

1. Antihistamines_____
2. Alcohol_____
3. Tobacco_____
4. Coffee_____
5. Artificial Sweeteners_____
6. Diet pop_____

FAMILY HISTORY

Many health problems are the results of hereditary weaknesses. This information about your family will give us a better understanding of your total health picture:

Have you or any of your siblings, parents, or grandparents had the following? (mark yes or no and who)
(GM-Grandmother, **GF**-Grandfather, **PGM**-Paternal Grandmother, **PGF**-Paternal grandfather)

1. Heart disease/attack_____
2. Cancer_____
3. Cerebral vascular/stroke_____
4. Respiratory disease_____
5. Gastrointestinal disease, crohns, ulcers
6. Diabetes_____
7. Mental illness or social dysfunctions_____
8. Kidney disease_____
9. Rheumatoid arthritis_____
10. Thyroid disease_____
11. High blood pressure_____
12. Allergies_____
13. Scoliosis_____

SOCIAL HISTORY

Recreation: Running Biking Weights ect. Frequency/Week Intensity – mild moderate intense

_____ _____ _____

_____ _____ _____

Rehab/Diet Programs:

Name: Frequency/Week Intensity – mild moderate intense

_____ _____ _____

_____ _____ _____

Do you carry items such as tools, cell phone, radios on your belt? _____

Do you have any tattoos or body piercings, If so please indicate:

Location(s): _____ Dates:_____

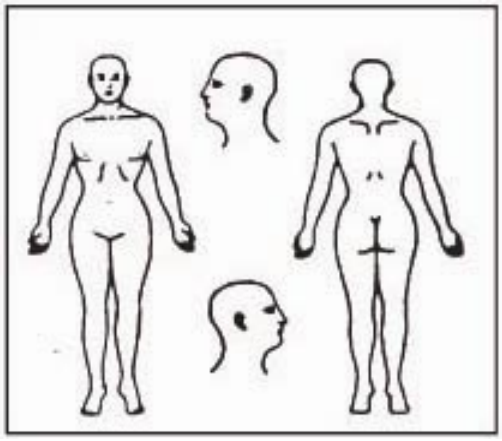
_____ _____

Do you currently wear any of the following?

Arch Supports _____ Heel Lifts_____ Other supports _____

Do they help? _____

Please mark your areas of pain on the figures below.



List the conditions that you are most interested in getting corrected.

List in order of importance:

1. _____
2. _____
3. _____
4. _____

List 3 basic health goals that you would like to achieve:

1. _____
2. _____
3. _____

List previous medical diagnosis and treatments you have received for your present condition(s).

_____

_____

What do you think causes or has caused your concern or what has aggravated concern? _____

_____

_____

 # 1 Symptom Description_____

Date First Noticed_____ (Circle one) Onset:

Related to an Accident: ☐ Yes ☐ No Date of Accident:_____

Description of Accident:_____

Location of Accident: Other

Limitations since condition began:_____

Severity of Pain (10 being the worst pain imaginable):

How often do you feel pain: _____ % of the awake time.

Quality of Pain: Other/Comments

Does the pain radiate to anywhere else? If so, to where?_____

It is ***better*** when I: Other

It is ***worse*** when I: Other

Is there a time of the day/month/year when the symptom is worse? ☐ Yes ☐ No

If so, when?_____

Previous treatment for the above condition:_____

Did it help?_____

 # 2 Symptom Description_____

Date First Noticed_____ (Circle one) Onset:

Related to an Accident: ☐ Yes ☐ No Date of Accident:_____

Description of Accident:_____

Location of Accident: Other

Limitations since condition began:_____

Severity of Pain (10 being the worst pain imaginable):

How often do you feel pain: _____ % of the awake time.

Quality of Pain: Others/Comments

Does the pain radiate to anywhere else? If so, to where?_____

It is ***better*** when I: Other

It is ***worse*** when I: Other

Is there a time of the day/month/year when the symptom is worse? ☐ Yes ☐ No

If so, when?_____

Previous treatment for the above condition:_____

Did it help?_____

ACTIVITIES OF DAILY LIVING

Check the appropriate space for activities you have PAIN or DIFFICULTY with:

1. Bending/Twisting/Turning ☐
2. Dressing the upper body ☐
3. Dressing the lower body ☐
4. Grooming/bathing ☐
5. Going to the bathroom ☐
6. Meal preparation/clean-up ☐
7. Dusting, sweeping, cleaning ☐
8. Vacuuming ☐
9. Doing Laundry ☐
10. Needlework, Knitting, Hand Sewing ☐
11. Driving/riding in car ☐
12. Getting in and out of the car ☐
13. Climbing stairs ☐
14. Sitting ☐
15. Walking ☐
16. Running ☐
17. Recreational Activities ☐
18. Work Habits ☐
19. Yard work ☐
20. Typing/Computer Work ☐
21. Reading ☐
22. Sexual Intercourse ☐
23. Shopping ☐
24. Carrying Groceries ☐
25. Sleeping ☐
26. Ironing ☐
27. Taking care of baby/child ☐

INSURANCE AND/OR BENEFITS RELEASE

I hereby authorize Dr. Dean B. McGee/McGee Kinesiology P.A. **and/or** Dr. Thane J. Perrier/Perrier Kinesiology P.A. to furnish my insurance carrier, benefits agent, attorney, and any physician, any and all information regarding my health and treatment during any course of care at McGee Kinesiology and/or Perrier Kinesiology. This includes copies of medical examination findings, x-ray reports, progress notes, and my financial account.

I also authorize payment directly to Dr. Dean B. McGee/McGee Kinesiology P.A. **and/or** Dr. Thane J. Perrier/Perrier Kinesiology P.A., of the allowed benefits or insurance coverage for all McGee Kinesiology and/or Perrier Kinesiology service fees, otherwise payable directly to me.

I agree to pay, at the time of services, the portion of the charges not covered by my benefits or primary insurance.

I agree to pay, at the time of service, charges for services that extend beyond my primary referral.

I understand that a reasonable effort will be made to secure payment from my benefit plan or primary insurance carrier through normal claims processing means.

Following the last response to the final charge on my account, I promise to pay within sixty (60) days any balance left owing.

A copy of this authorization shall be considered to have the same validity as the original.

Signed_____ Date_____

CONSENT FOR PERSONAL TREATMENT

"I hereby authorize Dr. Dean B. McGee/McGee Kinesiology P.A. **and/or** Dr. Thane J. Perrier/Perrier Kinesiology P.A., to administer chiropractic care to me."

Signed_____ Date_____

CONSENT FOR TREATMENT OF MINOR CHILD

"I hereby authorize Dr. Dean B. McGee/McGee Kinesiology P.A. **and/or** Dr. Thane J. Perrier/Perrier Kinesiology P.A., to administer chiropractic care to_____(name of child) who is my_____ _____(child's relationship to you)."

Signed_____ Date_____