

Name: \_\_\_\_\_

Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



*Leaders in Muscle and Joint Performance*  
*"A move in the right direction"*

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[www.musldoc.com](http://www.musldoc.com)

#### Patient Information Sheet

Name: \_\_\_\_\_ Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_

Relationship status (circle one): Married Single Divorced Widowed Minor

Primary Phone (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Phone (\_\_\_\_) \_\_\_\_\_

Family Members: \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Duties: \_\_\_\_\_

**Referred to our office by:** \_\_\_\_\_

#### **Responsible Party: (if different)**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone (\_\_\_\_) \_\_\_\_\_ Emergency Phone (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_

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### MEDICAL HISTORY

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

Yes  No  (If so, please describe) \_\_\_\_\_

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 at any time (include work/auto)

Date

Residual Symptoms

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

#### Have you ever had any fractures?

Date

Residual Symptoms

1. \_\_\_\_\_

2. \_\_\_\_\_

Adult illnesses or conditions: \_\_\_\_\_

\_\_\_\_\_

Current Height: \_\_\_\_\_ Ft \_\_\_\_\_ Inches    Current Weight: \_\_\_\_\_ lbs

What is your general state of health today? Excellent  Good  Fair  Poor

When was the last time you really felt good? \_\_\_\_\_ Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years

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

Have you received Chiropractic care in the past? Yes, currently  Yes, previously  No

If yes, Name of Clinic / Doctor: \_\_\_\_\_

Type of treatment \_\_\_\_\_

Total time under care \_\_\_\_\_ Was treatment helpful? \_\_\_\_\_

Name of Medical physician \_\_\_\_\_ Phone (optional) \_\_\_\_\_

Date of last physical / exam \_\_\_\_\_ What prompted the exam \_\_\_\_\_

Date of most recent x-rays \_\_\_\_\_ Parts of body x-rayed \_\_\_\_\_

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**Do you currently take:** (to help the doctor, please note NAME of medication, HOW MUCH you take along with HOW LONG you have taken them)

1. Vitamins/supplements/herbs Yes No \_\_\_\_\_  
\_\_\_\_\_
2. Birth control pills Yes No \_\_\_\_\_
3. Over the counter drugs Yes No \_\_\_\_\_
4. Sedatives/tranquilizers Yes No \_\_\_\_\_
5. Pain killers/ muscle relaxers Yes No \_\_\_\_\_
6. Blood pressure medicine Yes No \_\_\_\_\_
7. Insulin Yes No \_\_\_\_\_
8. Laxatives Yes No \_\_\_\_\_
9. Recreational drugs Yes No \_\_\_\_\_
10. Other Yes No \_\_\_\_\_  
\_\_\_\_\_

**How often do you use:**

1. Antihistamines	Daily	Weekly	Monthly	Other _____
2. Alcohol	Daily	Weekly	Monthly	Other _____
3. Tobacco	Daily	Weekly	Monthly	Other _____
4. Coffee	Daily	Weekly	Monthly	Other _____
5. Artificial Sweeteners	Daily	Weekly	Monthly	Other _____
6. Diet pop	Daily	Weekly	Monthly	Other _____

## 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. If you or any of your siblings, parents, or grandparents had the following, mark all that apply: **M**-Me, **P**-Parent, **S**-Sibling, **GP**-Grandparent

1. Heart disease/attack \_\_\_\_\_
2. Cancer \_\_\_\_\_
3. Cerebral Vascular/Stroke \_\_\_\_\_
4. Respiratory disease \_\_\_\_\_
5. Mental illness or social dysfunctions \_\_\_\_\_
6. Diabetes \_\_\_\_\_
7. Gastrointestinal disease, Crohn's, ulcers \_\_\_\_\_
8. Kidney disease \_\_\_\_\_
9. Rheumatoid Arthritis \_\_\_\_\_
10. Thyroid disease \_\_\_\_\_
11. High blood pressure \_\_\_\_\_
12. Allergies \_\_\_\_\_
13. Scoliosis \_\_\_\_\_

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### SOCIAL HISTORY

**Recreation:** Running, Biking, Weights etc.

Frequency/Week

Intensity

**Rehab/Diet Programs:** Paleo, GF, etc.

Frequency/Week

Intensity

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?

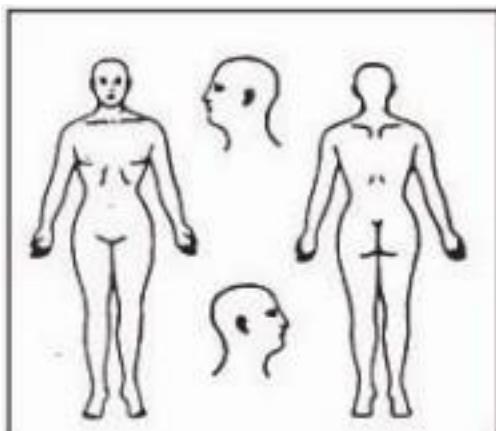
Arch Supports Yes No      Heel Lifts Yes No      Other supports Yes No

If other, please indicate type of support \_\_\_\_\_

Do you feel like they help? \_\_\_\_\_

**Please mark your areas of pain**

**on the figures below**



List the conditions that you are most interested in getting corrected 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 condition(s), or what has aggravated your condition(s)?

\_\_\_\_\_

Name: \_\_\_\_\_

Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**# 1 Symptom** (please describe) \_\_\_\_\_

Date First Noticed \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Onset (Circle one): Sudden Gradual

Related to an Accident: Yes No Date of Accident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Description of Accident: \_\_\_\_\_

Location of Accident: Home Work School Other \_\_\_\_\_

Limitations since condition began: \_\_\_\_\_

Severity of Pain 1 2 3 4 5 6 7 8 9 10 (10 being the worst pain imaginable)

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

Quality of Pain: Sharp Dull Achy Burning Numb Pins & Needles Gnawing No Pain  
Weakness Other \_\_\_\_\_

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

It is **better** when I: Sit Stand Lie Down Rest Exercise Ice Other \_\_\_\_\_

It is **worse** when I: Sit Stand Lie Down Rest Exercise 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** (please describe) \_\_\_\_\_

Date First Noticed \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Onset (Circle one): Sudden Gradual

Related to an Accident: Yes No Date of Accident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Description of Accident: \_\_\_\_\_

Location of Accident: Home Work School Other \_\_\_\_\_

Limitations since condition began: \_\_\_\_\_

Severity of Pain 1 2 3 4 5 6 7 8 9 10 (10 being the worst pain imaginable)

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

Quality of Pain: Sharp Dull Achy Burning Numb Pins & Needles Gnawing No Pain  
Weakness Other \_\_\_\_\_

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

It is **better** when I: Sit Stand Lie Down Rest Exercise Ice Other \_\_\_\_\_

It is **worse** when I: Sit Stand Lie Down Rest Exercise 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? \_\_\_\_\_

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## ACTIVITIES OF DAILY LIVING

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

	Always	Sometimes	Never
1. Bending/Twisting/Turning	_____	_____	_____
2. Dressing the upper body	_____	_____	_____
3. Dressing the lower body	_____	_____	_____
4. Going to the bathroom	_____	_____	_____
5. House work	_____	_____	_____
6. Driving/riding in car	_____	_____	_____
7. Getting in and out of the car	_____	_____	_____
8. Climbing stairs	_____	_____	_____
9. Sitting	_____	_____	_____
10. Walking	_____	_____	_____
11. Recreational Activities	_____	_____	_____
12. Work Habits	_____	_____	_____
13. Yard work	_____	_____	_____
14. Typing/Computer Work	_____	_____	_____
15. Sexual Intercourse	_____	_____	_____
16. Carrying Groceries / Small Child	_____	_____	_____
17. Sleeping	_____	_____	_____

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### **Scope of Care & Provider Role (Kansas)**

I understand that in the state of Kansas, Doctors of Chiropractic are recognized as portal-of-entry providers and may serve as a primary point of contact for musculoskeletal and related functional concerns.

I further understand that McGee & Perrier Kinesiology does not replace primary medical care when such care is indicated and that referral to, or collaboration with, medical providers may be recommended when appropriate.

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### **Consent for Examination and Treatment**

I hereby request and consent to the evaluation, examination, and treatment provided by Dr. Dean McGee and/or Dr. Thane Perrier, Doctors of Chiropractic, and their staff, at McGee & Perrier Kinesiology.

I understand that chiropractic care, soft tissue therapy, rehabilitation procedures, and integrative or functional-based care involve physical evaluation and treatment intended to improve function, mobility, and overall health. I acknowledge that, as with any healthcare service, there are inherent risks, and that no specific results or outcomes can be guaranteed.

I understand that I may ask questions at any time regarding my care and that I have the right to refuse or discontinue treatment at any point.

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### **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 \_\_\_\_\_