Name: _____ Date of birth: _____ / _____/_____

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

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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:_____ Date of birth: _____ / _____/_____

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_____
3._____

Adult illnesses or conditions: _____
_____

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 _____

Name:_____ Date of birth: _____ / _____/_____

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_____

Name:_____ Date of birth: _____ / _____/_____

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: _____

_____ _____

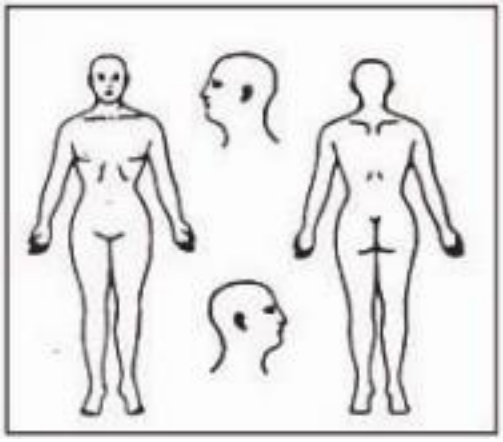
Do you currently wear any of the following?

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?_____

Name:_____ Date of birth: _____ / _____/_____

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	_____	_____	_____

Name:_____ Date of birth: _____ / _____/_____

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.

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.

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_____