TRUE PERFORMANCE

RANCHO SANTA FE

## PATIENT INFORMATION

Name:_____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: ____ Zip: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Spouses Name: _____

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

Preferred Contact: ☐ Home/Cell ☐ Work ☐ Email Other: _____

Emergency Contact: _____ Relation: _____ Phone#: (_____)_____

Are you: ☐ Employed ☐ Unemployed ☐ Retired Occupation: _____

Are you a Student: ☐ Yes ☐ No ☐ Full Time ☐ Part Time School: _____

Who may we thank for referring you to our office? _____

## ACCIDENT INFORMATION (IF APPLICABLE)

Is your current condition related to an accident? ☐ Yes ☐ No

Date of Accident: ____/____/_____ Type of Accident: Auto Work Other: _____

Claim#: _____ Adjuster: _____ Phone#: (_____)_____

Who is representing you in this case? _____

## ***NOTICE OF PRIVACY PRACTICE SUMMARY***

This summary discloses how health information about you may be used. At your request, McWhorter CNR can provide you with the full notice of your privacy rights. McWhorter CNR uses health information about you for treatment and to obtain payment for treatment with your authorization. McWhorter CNR will not disclose your information to others unless you tell us to do so or unless the law authorizes or requires us to do so.

## ***ASSIGNMENT AND RELEASE***

I, undersigned certify that I (or my dependent) have insurance coverage and assign directly to McWhorter CNR all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am personally liable for any charges, whether or not paid by insurance, for services rendered to me. I hereby authorize doctors to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

## FINANCIAL RESPONSIBILITY

I understand that all services rendered to me are charged directly to me and that I am personally responsible for any payment at the time of service (includes Health Insurance Co-pays/Deductibles/Co-insurance).

## ***CONSENT FOR TREATMENT OF MINORS***

Patient/Guardian Signature: _____ Date: _____

Name: _____

Please describe your symptoms: _____

_____

_____

Date your symptoms began: _____/_____/_____

What describes the nature of your symptoms?:

☐ Sharp ☐ Dull ache ☐ Numbness ☐ Shooting ☐ Burning ☐ Tingling ☐ Dizziness ☐ Other _____

Average pain intensity (None 1 – 10 Worse)

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Last 24 hours | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Past Week | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

How much has your pain interfered with your daily activities (work, social activities, or household chores?)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How often are your symptoms present?

(Intermittent) ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% (Constantly)

Have you ever seen a Chiropractor in the past? ☐ Yes ☐ No

Who have you seen for your current symptoms? ☐ No one ☐ Chiropractor ☐ Primary Doctor ☐ Physical Therapist ☐ Other: _____

What treatment did you receive and when? _____

Last date: X-rays: _____ MRI: _____ CT Scan: _____

In general, how would you say your overall health is right now?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

## HEALTH HISTORY

Please check all of the following you have had in the past:

| | | | |
|---|---|---|---|
| ☐ Aids/HIV | ☐ Cancer | ☐ Kidney Disease | ☐ Thyroid Problem |
| ☐ Anemia | ☐ Cataracts | ☐ Liver Disease | ☐ Tuberculosis |
| ☐ Anorexia | ☐ Diabetes | ☐ Multiple Sclerosis | ☐ Tumors |
| ☐ Appendicitis | ☐ Epilepsy | ☐ Parkinson's Disease | ☐ Ulcers |
| ☐ Arthritis | ☐ Gout | ☐ Pinched Nerve | ☐ Varicose Veins |
| ☐ Asthma | ☐ Heart Disease | ☐ Pneumonia | ☐ Currently Pregnant |
| ☐ Blood Clots | ☐ Herniated Disk | ☐ Pollo | ☐ Psychiatric Care |
| ☐ Breast Lump | ☐ High Blood | ☐ Prosthesis | ☐ Other: _____ |
| ☐ Bronchitis | ☐ Pressure | ☐ Seizures | _____ |
| ☐ Bulging Disk | ☐ High Cholesterol | ☐ Strokes | _____ |

Injuries/Surgeries you have had:

Accidents/Falls: _____ Head Injuries: _____

Broken Bones: _____ Dislocations: _____

Surgeries: _____

## FAMILY HISTORY

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Problems/Stroke

Medications: _____ Allergies: _____ Vitamins/Supps: _____

_____ _____ _____

I certify to the best of my knowledge, the above information is complete and accurate. I agree to notify Dr. McWhorter immediately whenever I have changes in my health condition.

Patient/Gaurdian Signature: _____ Date: _____