MADDAS
CHIROPRACTIC

870 McClellandtown Rd., McClellandtown, PA 15458

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Phone: (724) 430.4924

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WELCOME!

PATIENT INFORMATION

Date: _____

First Name: _____ Last Name: _____ Middle initial: _____

Email address: _____
(Email will not be shared and is used for office purposes only).

Mailing address: _____ City: _____ State: _____ Zip: _____

Telephone (cell): _____ (home)_____

Age:_____ Sex: ___ Male ___ Female Birth Date: _____

Social Security #: _____

Referred by: _____

Occupation/student: _____ Employer/school: _____

Work/school address: _____ Work/school phone #: _____

Marital status: __ Single __ Married __ Divorced __ Widowed __ Separated __ Minor __ Partnered

Spouse name: _____ Spouse occupation: _____

Spouse Employer: _____ Spouse work phone #: _____

Emergency Contact: _____Phone: _____

Current Complaints

Nature of complaint: _____ Auto _____ Work _____ Personal injury _____ Other

Please describe: _____

_____

Date of injury: _____ Date symptoms appeared: _____

Have you ever had same condition: Y N If "yes" when? _____

List other practitioners for this injury/condition: _____

Have you ever been under chiropractic care? Y N If "yes" describe? _____

Insurance Information

Do you have health insurance? Y N

Who is responsible for this account? _____ Relationship to patient: _____

Is patient cover by additional insurance? __Y __N

Subscriber name: _____ Date of birth: _____ Social Security #: _____

Address: _____ Contact #: _____

Name of Insured: _____ Phone #: _____

Address: _____ Date of birth: _____ Social Security#: _____

Name of insurance company: _____ Policy #: _____Group#: _____

Assignment & Release

I certify that I and/or dependent(s) have insurance coverage with _____ and assign

(Name of Insurance Company[s])

directly to Dr. _____ all insurance benefits, if any otherwise, payable to me for services rendered. I understand that I am financially responsible for all charges, whether paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

(Signature of patient, parent, guardian, or personal representative).

(Please print name of patient, parent, guardian, or personal representative).

Date: _____ Relationship to patient: _____

Accident Information

Is condition due to an accident? __ Y __ N

Type of accident: __ Auto Accident ___ Work __ Home __ Other

Date of accident: _____ To whom have you made a report of the accident?

__ Auto Insurance __Employer __ Workers' Comp __ Other

Attorney's name (if applicable): _____ Phone #: _____

*Auto Insurance name: _____ Contact #: _____

*Name of Employer: _____ Contact #: _____

*Name of Other: _____ Contact #: _____

SIGNATURE

Name of the Insured: _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's signature: _____ Date: _____

Spouse's or guardian's signature _____ Date: _____

Medical Health History

Have you treated for any conditions in the last year? ___Y ___N If yes, please describe: _____

_____

What treatment have you already received for your condition? __ Medications __ Surgery __Physical Therapy

__Chiropractic Services __ None __Other _____

Date of last: physical exam? _____ Is there a chance you may be pregnant? ___ Y ___ N

Spinal exam? _____ Spinal X-ray? _____ Chest X-ray? _____ MRI, CT scan, Bone scan? _____

Dental X-ray? _____ Blood Test? _____ Urine Test? _____

Have you had X-Rays taken? ___ Y ___ N If yes, where? _____

What medications are you taken and for what condition(s)? _____
(Please list dosage and amounts)

_____

Are you taking any: ___ Vitamins ___Herbs ___ Minerals ___ Other

What are they and amount? _____

_____

Pharmacy Name: _____ Phone #: _____

*Exercise: __ None __ Moderate __Daily __Heavy

*Work Activity: __ Sitting __ Standing __ Light Labor __Heavy Labor

*

Have you ever: ***Briefly explain:***

Broken bones? ___ Y ___ N _____

Been hospitalized? ___ Y ___ N _____

Been in an auto accident? ___ Y ___ N _____

Had Sprains/Strains? ___ Y ___ N _____

Been struck unconscious? ___ Y ___ N _____

Had surgery? ___ Y ___ N _____

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

_____

_____

_____

Do you experience pain every day? ___ Y ___ N

Do your symptoms interfere with daily life? ___ Y ___ N

Does pain wake you up at night? ___ Y ___ N

Are your symptoms worse during certain times of the day? ___ Y ___ N

Do changes in weather affect your symptoms? ___ Y ___ N

Do you wear orthotics? ___ Y ___ N

What activities aggravate your symptoms? ___ Y ___ N

Habits

High Stress Level: Reason: _____

Alcohol ___ Y ___ N Light Moderate Heavy, Drinks/week: _____

Coffee ___ Y ___ N Light Moderate Heavy, Cups/day: _____

Tobacco/Smoking ___ Y ___ N Light Moderate Heavy, Packs/day: _____

Drugs ___ Y ___ N Light Moderate Heavy

Exercise ___ Y ___ N Light Moderate Heavy

Sleep ___ Y ___ N Light Moderate Heavy

Appetite ___ Average ___ Good ___ Poor

Soft Drinks ___ Y ___ N How often? _____

Water ___ Y ___ N How much per day? _____

Salty Foods ___ Y ___ N Light Moderate Heavy

Sugary Foods ___ Y ___ N Light Moderate Heavy

Artificial Sweetener ___Y ___ N Light Moderate Heavy

Alcoholism ___Y ___ N

Allergies ___Y ___ N

Arthritis ___Y ___ N

Back Pain ___Y ___ N

Bruise Easily ___Y ___ N

Chest Pain/Conditions ___Y ___ N

Constipation ___Y ___ N

Depression	___Y ___ N		
Digestion Problems	___Y ___ N	Fatigue	___Y ___ N
Headache	___Y ___ N	High Blood Pressure	___Y ___ N
Loss of balance	___Y ___ N	Neck Pain or Stiffness	___Y ___ N
Poor Posture	___Y ___ N	Sciatica	___ Y ___ N
Shortness of breath	___ Y ___ N	Sleep problems/Insomnia	___ Y ___ N
Spinal Curvatures	___ Y ___ N	Swelling of ankles	___ Y ___ N
Swollen Joints	___ Y ___ N		

Other: _____

Patient Condition

Reason For Your Visit: _____

When did your symptoms appear? _____ Is this condition getting worse? ___ Y __ N __ unknown

Rate the severity of each symptom on a scale of (1) least pain & (10) severe pain:

____ Sharp ____ Burning ____ Dull ____Tingling ___ Throbbing ___Cramps ___ Numbness ___Stiffness

____ Aching ____ Swelling ____ Other

How often do you have this pain? _____

Body Pain Indicator

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A= Ache

B= Burning

N= Numbness

S= Stabbing

P= Pins & Needles

O= Other