DR. BRIAN MCDONOUGH | CHIROPRACTOR

NEW PATIENT FORM

Name _____ Home phone _____

Address _____ Cell phone _____

City _____ Email _____

State _____ Zip _____ ☐ TEXT ☐ CALL ☐ LEAVE MESSAGE

Social Security # _____ Patient date of birth _____

Occupation _____ Age _____ Gender _____

Patient Employer _____ Marital Status _____

Employer Phone # _____ Spouse Name _____

Referred by _____ Spouse Employer _____

Insurance _____ Emergency Contact Name _____

Insured Person's Name _____ Emergency Contact # _____

Insured Person's date of birth _____ ☐ TEXT ☐ CALL ☐ LEAVE MESSAGE

Body area that is hurting _____

How did this area get injured _____

Was this: ☐ Job related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other _____

Other doctors seen for this condition _____

Prescriptions _____

Major Surgery _____

Major Accidents or Falls _____

Hospitalization _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any reports and forms to assist me in making collection from the insurance company ad that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate , any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that they are responsible for all billed incurred at the office.

Please do not sign digitally or manually. We will have you sign the form in-person.

Patient signature: _____ Date _____

Consent to treat a Minor _____ Date _____

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

Have you tested HIV positive: ☐ YES ☐ NO

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ Sugar

CHECK ANY OF THE FOLLOWING YOU HAD IN THE PAST 6 MONTHS

- ☐ Low Back Pain
- ☐ Heartburn
- ☐ Arm Pain
- ☐ Walking Problems
- ☐ Painful/Excessive Urination
- ☐ Nervous
- ☐ Short Breath
- ☐ Dizziness
- ☐ Lungs Issues/Congestion
- ☐ Fainting
- ☐ Stroke
- ☐ Fatigue
- ☐ Dental Issues
- ☐ Fever
- ☐ Hearing Difficulty
- ☐ Excessive Thirst
- ☐ Abdominal Cramps
- ☐ Constipation
- ☐ Gas/Bloating after meals
- ☐ Neck Pain
- ☐ Colitis
- ☐ Bladder Control
- ☐ General Stiffness
- ☐ Chest Pain
- ☐ Paralysis
- ☐ Heart Issues
- ☐ Confusion/Depression
- ☐ Ankle Swelling
- ☐ Cold/Tingling Extremities
- ☐ Vision Issues
- ☐ Loss of sleep
- ☐ Ear Aches
- ☐ Poor/Excessive Appetite
- ☐ Weight Trouble
- ☐ Vomiting
- ☐ Liver Issues
- ☐ Pain between shoulders
- ☐ Black/Bloody stool
- ☐ Joint Pain/Stiffness
- ☐ Difficult Chewing/Clicking Jaw
- ☐ Discolored Urine
- ☐ Numbness
- ☐ Blood Press Issues
- ☐ Forgetfulness
- ☐ Varicose Veins
- ☐ Convulsions
- ☐ Stress
- ☐ Allergies
- ☐ Sore Throat
- ☐ Headaches
- ☐ Gall bladder
- ☐ Frequent Nausea
- ☐ Diarrhea

FEMALE:

Last menstrual period_____

Are you pregnant: ☐ YES ☐ NO ☐ NOT SURE

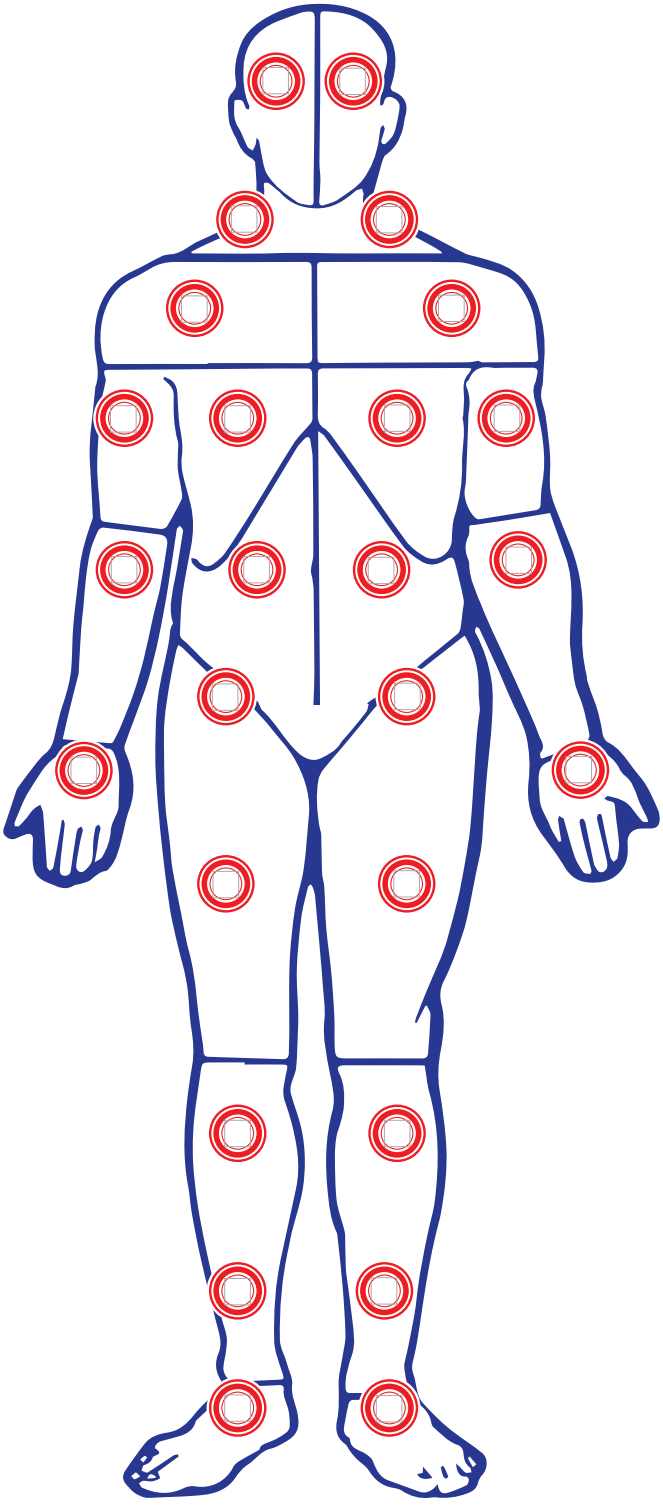
- ☐ Menstrual Cramps

MALE:

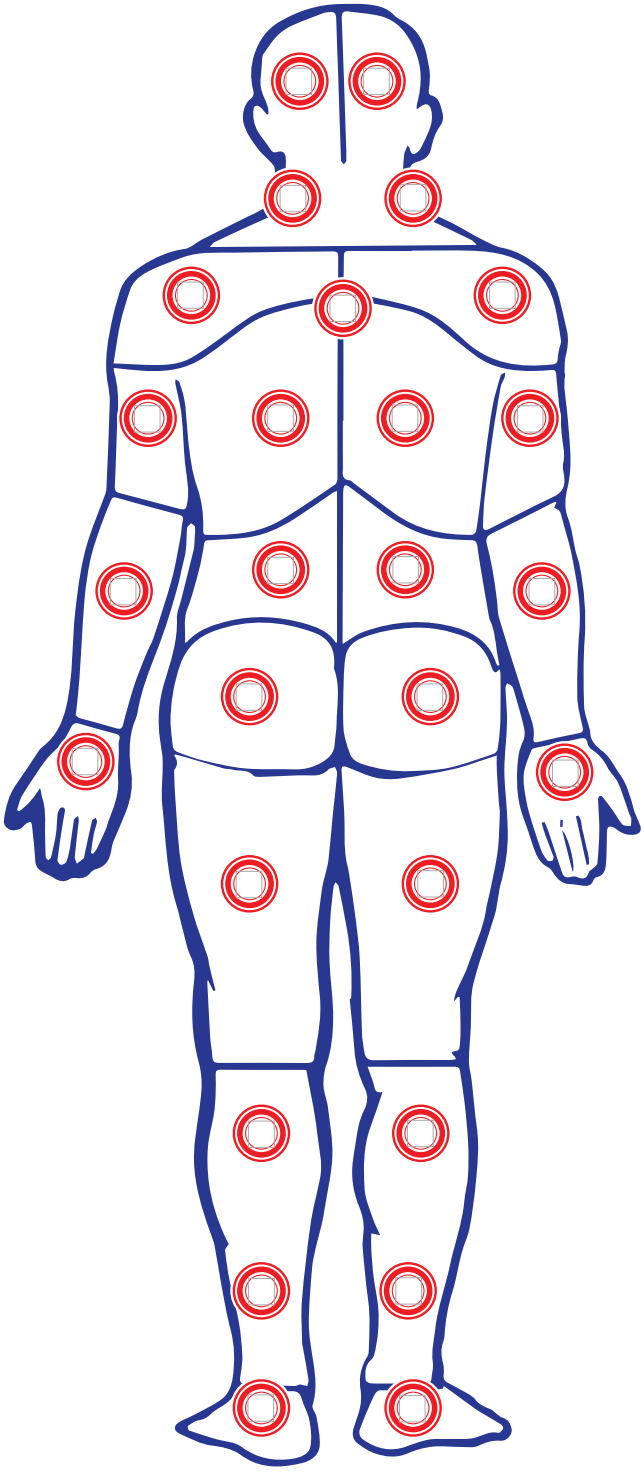
- ☐ Prostate Pain

Please check the red circles below wherever you are feeling pain or discomfort

FRONT



BACK



When all forms are complete, please click the send button to email it directly to us. If you filled out by hand, please print the documents and bring them to your initial visit. Thank you very much!

SEND