Dr. Mackey's Family Chiropractic, PSC

Patient Name: _____ Case # _____ Date: _____

Address_____ City_____State_____ Zip_____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth_____ Age_____

Social Security #_____

Occupation_____

Employer_____

Have you ever received Chiropractic Care? Yes/No If yes, when? _____

Name of most recent Chiropractor:

_____

1. Reasons for seeking chiropractic care:

Primary reason:

_____

_____

Secondary reason:

_____

_____

2. Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):

_____

_____

_____

100 Baughman Ave., Suite B, Danville, KY 40422 Phone: 859-238-9300 Fax: 859-238-9977

3. Past Health History:

A. Please indicate if you have a history of any of the following:

□ Anticoagulant use
□ Bleeding problems
□ Cancer
□ Psychiatric disorders
□ Major depression
□ Stroke/TIA's
□ None of the above
□ Heart problems/high blood pressure/chest pain
□ Lung problems/shortness of breath
□ Diabetes □ type 1 □ type 2
□ Bipolar disorder
□ Schizophrenia
□ Other _____

B. Previous Injury or Trauma:

_____

Have you ever broken any bones? Which?

_____

C. Allergies:

_____

D. Medications:

Medication Name	Reason for taking	Dose	how often

E. Surgeries:

Date	Type of Surgery (if hysterectomy - with or w/o ovaries)

F. Females/ Pregnancies and outcomes:

Pregnancies/Date of Delivery	Outcome

100 Baughman Ave., Suite B, Danville, KY 40422 Phone: 859-238-9300 Fax: 859-238-9977

Dr. Mackey's Family Chiropractic, PSC

Patient Name: _____ Case # _____ Date: _____

4. Family Health History:

Do you have a family history of? (Please indicate all that apply)

□ Cancer
□ Headaches
□ Neurological diseases
□ Cardiac disease below age 40
□ Diabetes
□ None of the above
□ Strokes/TIA's
□ Cardiac disease
□ Adopted/Unknown
□ Psychiatric disease
□ Other _____

Deaths in immediate family:

_____

Cause of parents or siblings death Age at death

_____
_____
_____
_____
_____

5. Social and Occupational History:

A. Job description:

_____

B. Work schedule:

_____

C. Recreational activities:

_____

D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):

_____

100 Baughman Ave., Suite B, Danville, KY 40422 Phone: 859-238-9300 Fax: 859-238-9977

100 Baughman Ave., Suite B, Danville, KY 40422 Phone: 859-238-9300 Fax: 859-238-9977

Dr. Mackey's Family Chiropractic, PSC

Patient Name: _____ Case # _____ Date: _____

Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?

□ Asthma/difficulty breathing
□ COPD
□ Emphysema
□ Other _____
□ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?

□ Heart surgeries
□ Congestive heart failure
□ Murmurs or valvular disease
□ Heart attacks/MIs
□ Heart disease/problems
□ Hypertension
□ Pacemaker
□ Angina/chest pain
□ Irregular heartbeat
□ Other _____
□ None of the above

Have you had any of the following **neurological (nerve-related)** issues?

□ Visual changes/loss of vision
□ One-sided weakness of face or body
□ History of seizures
□ Memory loss
□ Headaches
□ Vertigo
□ Tremors
□ Strokes/TIAs
□ Loss of sense of smell
□ Other _____
□ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?

□ Thyroid disease
□ Hormone replacement therapy
□ Other _____
□ Diabetes □ type 1 □ type 2
□ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?

□ Renal calculi/stones
□ Hematuria (blood in the urine)
□ Incontinence (can't control)
□ Bladder Infections
□ Difficulty urinating
□ Kidney disease
□ Dialysis
□ Other _____
□ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?

□ Nausea
□ Difficulty swallowing
□ Ulcerative disease
□ Frequent abdominal pain
□ Hiatal hernia
□ Constipation
□ Pancreatic disease
□ Irritable bowel/colitis
□ Hepatitis or liver disease
□ Bloody or black tarry stools
□ Vomiting blood
□ Bowel incontinence
□ Gastroesophageal reflux/heartburn
□ Other _____
□ None of the above

100 Baughman Ave., Suite B, Danville, KY 40422 Phone: 859-238-9300 Fax: 859-238-9977

Review of Systems (continued)
Have you had any of the following **hematological (blood-related)** issues?

□ Anemia
□ Abnormal bleeding/bruising
□ Enlarged lymph nodes
□ Anticoagulant therapy
□ HIV positive
□ Sickle-cell anemia
□ Hemophilia
□ Other _____
□ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve)
□ Hypercoagulation or deep venous thrombosis/history of blood clots
□ None of the above

Have you had any of the following **dermatological (skin-related)** issues?

□ Significant burns/grafts
□ Other _____
□ Significant rashes
□ Psoriatic disorders
□ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?

□ Rheumatoid arthritis/Osteoarthritis
□ Spinal fracture
□ Joint surgery
□ Scoliosis
□ Other _____
□ Gout
□ Broken bones
□ Spinal surgery
□ Arthritis (unknown type)
□ Metal implants
□ None of the above

Have you had any of the following **psychological** issues?

□ Psychiatric diagnosis
□ Suicidal ideations
□ Homicidal ideations
□ Psychiatric hospitalizations
□ Depression
□ Bipolar disorder
□ Schizophrenia
□ Other _____
□ None of the above

Is there anything else in your past medical history that you feel is important to your care here?
_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Dr. Mackey's Family Chiropractic, PSC for services performed.

Patient or Guardian Signature _____

Date_____

100 Baughman Ave., Suite B, Danville, KY 40422 Phone: 859-238-9300 Fax: 859-238-9977

Dr. Mackey's Family Chiropractic, PSC

Patient Name: _____ Case # _____ Date: _____

NEW PATIENT HISTORY FORM

Area of Pain (worst) _____ □ Left □ Right □ Both
(in decreasing order, please)

- Describe the quality of the symptom (circle all that apply):

  Aching, acute, burning, constant, cramping, deep, diffuse, dull, fullness, heavy, intermittent, lancinating, localized, mild, moderate, painful to touch, persistent, piercing, pressing, severe, sharp, shooting, squeezing, stabbing, superficial, throbbing, tightening, tightness, vague discomfort, well localized pain, other (please describe):
  _____

- Does the symptom radiate to another part of your body (circle one): yes no

  If yes, where does the symptom radiate? _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____

  - Did the symptom begin suddenly or gradually? (circle one)

  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):

  - Bending neck forward, bending neck backward, tilting head left, tilting head right, turning head left, turning head right, bending or stooping, tilting left at waist, tilting right at waist, twisting, sitting, standing, getting out of chairs, lifting, movement, driving, walking, running, nothing, weight bearing,
  - other (please describe): _____

- What makes the symptom better? (circle all that apply):

  - Rest, ice, heat, stretching, exercise, massage, pain medications, muscle relaxers, nothing, other (please describe): _____

- Is the symptom worse at certain times of the day or night? (circle one)
  Morning Afternoon Evening Night Unaffected by time of day

100 Baughman Ave., Suite B, Danville, KY 40422 Phone: 859-238-9300 Fax: 859-238-9977

Area of Pain #2_____ □ Left □ Right □ Both

- Describe the quality of the symptom (circle all that apply):

  Aching, acute, burning, constant, cramping, deep, diffuse, dull, fullness, heavy, intermittent, lancinating, localized, mild, moderate, painful to touch, persistent, piercing, pressing, severe, sharp, shooting, squeezing, stabbing, superficial, throbbing, tightening, tightness, vague discomfort, well localized pain, other (please describe):
  _____

- Does the symptom radiate to another part of your body (circle one): yes no

  If yes, where does the symptom radiate? _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____

  - Did the symptom begin suddenly or gradually? (circle one)

  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):

  - Bending neck forward, bending neck backward, tilting head left, tilting head right, turning head left, turning head right, bending or stooping, tilting left at waist, tilting right at waist, twisting, sitting, standing, getting out of chairs, lifting, movement, driving, walking, running, nothing, weight bearing,
    other (please describe): _____

- What makes the symptom better? (circle all that apply):

  - Rest, ice, heat, stretching, exercise, massage, pain medications, muscle relaxers, nothing, other (please describe): _____

- Is the symptom worse at certain times of the day or night? (circle one)

  Morning Afternoon Evening Night Unaffected by time of day

100 Baughman Ave., Suite B, Danville, KY 40422 Phone: 859-238-9300 Fax: 859-238-9977

Dr. Mackey's Family Chiropractic, PSC

Patient Name: _____ Case # _____ Date: _____

Area of Pain #3 _____ □ Left □ Right □ Both

- Describe the quality of the symptom (circle all that apply):

  Aching, acute, burning, constant, cramping, deep, diffuse, dull, fullness, heavy, intermittent, lancinating, localized, mild, moderate, painful to touch, persistent, piercing, pressing, severe, sharp, shooting, squeezing, stabbing, superficial, throbbing, tightening, tightness, vague discomfort, well localized pain, other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no

  If yes, where does the symptom radiate? _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____

  - Did the symptom begin suddenly or gradually? (circle one)

  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):

  - Bending neck forward, bending neck backward, tilting head left, tilting head right, turning head left, turning head right, bending or stooping, tilting left at waist, tilting right at waist, twisting, sitting, standing, getting out of chairs, lifting, movement, driving, walking, running, nothing, weight bearing,
    other (please describe): _____

- What makes the symptom better? (circle all that apply):

  - Rest, ice, heat, stretching, exercise, massage, pain medications, muscle relaxers, nothing, other (please describe): _____

- Is the symptom worse at certain times of the day or night? (circle one)

  Morning Afternoon Evening Night Unaffected by time of day

100 Baughman Ave., Suite B, Danville, KY 40422 Phone: 859-238-9300 Fax: 859-238-9977

Area of Pain #4 _____ □ Left □ Right □ Both

- Describe the quality of the symptom (circle all that apply):

  Aching, acute, burning, constant, cramping, deep, diffuse, dull, fullness, heavy, intermittent, lancinating, localized, mild, moderate, painful to touch, persistent, piercing, pressing, severe, sharp, shooting, squeezing, stabbing, superficial, throbbing, tightening, tightness, vague discomfort, well localized pain, other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no

  If yes, where does the symptom radiate? _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____

  - Did the symptom begin suddenly or gradually? (circle one)

  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):

  - Bending neck forward, bending neck backward, tilting head left, tilting head right, turning head left, turning head right, bending or stooping, tilting left at waist, tilting right at waist, twisting, sitting, standing, getting out of chairs, lifting, movement, driving, walking, running, nothing, weight bearing,
    other (please describe): _____

- What makes the symptom better? (circle all that apply):

  - Rest, ice, heat, stretching, exercise, massage, pain medications, muscle relaxers, nothing, other (please describe): _____

- Is the symptom worse at certain times of the day or night? (circle one)

  Morning Afternoon Evening Night Unaffected by time of day

100 Baughman Ave., Suite B, Danville, KY 40422 Phone: 859-238-9300 Fax: 859-238-9977

Dr. Mackey's Family Chiropractic, PSC

Patient Name: _____ Case # _____ Date: _____

Area of Pain #5 _____ □ Left □ Right □ Both

- Describe the quality of the symptom (circle all that apply):

  Aching, acute, burning, constant, cramping, deep, diffuse, dull, fullness, heavy, intermittent, lancinating, localized, mild, moderate, painful to touch, persistent, piercing, pressing, severe, sharp, shooting, squeezing, stabbing, superficial, throbbing, tightening, tightness, vague discomfort, well localized pain, other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no

  If yes, where does the symptom radiate? _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____

  - Did the symptom begin suddenly or gradually? (circle one)

  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):

  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

- What makes the symptom better? (circle all that apply):

  - Rest, ice, heat, stretching, exercise, massage, pain medications, muscle relaxers, nothing, other (please describe): _____

- Is the symptom worse at certain times of the day or night? (circle one)

  Morning Afternoon Evening Night Unaffected by time of day

100 Baughman Ave., Suite B, Danville, KY 40422 Phone: 859-238-9300 Fax: 859-238-9977

Area of Pain #6 (least)_____ □ Left □ Right □ Both

- Describe the quality of the symptom (circle all that apply):

  Aching, acute, burning, constant, cramping, deep, diffuse, dull, fullness, heavy, intermittent, lancinating, localized, mild, moderate, painful to touch, persistent, piercing, pressing, severe, sharp, shooting, squeezing, stabbing, superficial, throbbing, tightening, tightness, vague discomfort, well localized pain, other (please describe): _____

- Does the symptom radiate to another part of your body (circle one): yes no

  If yes, where does the symptom radiate? _____

- On a scale from 1-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- When did the symptom begin? _____

  - Did the symptom begin suddenly or gradually? (circle one)

  - How did the symptom begin? _____

- What makes the symptom worse? (circle all that apply):

  - Bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, any movement, driving, walking, running, nothing, other (please describe): _____

- What makes the symptom better? (circle all that apply):

  - Rest, ice, heat, stretching, exercise, massage, pain medications, muscle relaxers, nothing, other (please describe): _____

- Is the symptom worse at certain times of the day or night? (circle one)

  Morning Afternoon Evening Night Unaffected by time of day

100 Baughman Ave., Suite B, Danville, KY 40422 Phone: 859-238-9300 Fax: 859-238-9977

Dr. Mackey's Family Chiropractic, PSC

Patient Name: _____ Case # _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

100 Baughman Ave., Suite B, Danville, KY 40422 Phone: 859-238-9300 Fax: 859-238-9977

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____

Signature of Patient of Representative Date

_____

Printed Name

100 Baughman Ave., Suite B, Danville, KY 40422 Phone: 859-238-9300 Fax: 859-238-9977