Dr. Jeffrey McKinley
358 Caldwell St.
McMinnville, TN 37110
931-473-2355

Patient Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: Home _____ Work _____ Cell _____

Email: _____ Birthday: _____/_____/_____

Gender: ☐Male☐Female Soc Sec #: _____ Marital Status: ☐Single☐Married☐Divorced☐Widowed

Spouse's Name: _____ Your nickname or name you preferred to be called: _____

Emergency Contact: _____ Emergency Phone: _____
How would you like to receive appointment reminders: ☐Text ☐Email ☐Both

Employer

Name: _____ Occupation: _____

City: _____ State: _____ Zip: _____ Phone: _____

Insurance

Ins Co: _____ Name of Insured _____

Birthdate of insured: ____/_____/_____ Relationship to insured:☐Self ☐Spouse ☐Dependent ☐Other

Policy Group #: _____ Insured ID #: _____

Acknowledgement

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form is completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- I have been presented and have had the opportunity to read the Consent to Chiropractic Examination and Treatment form. I have weighed the risks and/or benefits in undergoing treatment and have decided to proceed with evaluation and treatment.
- I have been presented and have had the opportunity to read the HIPPA Data Use Policy.

Patient/Guardian Signature: _____ Date: _____/_____/_____

Next ➡

Name _____ Date _____/_____/_____

Tell us about your symptom(s) today.

Symptom

Symptom start date

☐ Not sure when started
☐ Experienced before

On what side are you experiencing the symptoms?

☐ Left ☐ Right ☐ Both ☐ Central ☐ None

Rate the level of your symptoms? 0 is no pain, 10 is the worse pain ever in your life

☐ None ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What is the intensity of the pain?

☐ None ☐ Minimum ☐ Mild ☐ Moderate ☐ Severe ☐ Unbearable

What is the nature of the symptoms?

☐ Burning	☐ Cramping	☐ Crick	☐ Dull ache
☐ Generally achy, occasionally sharp		☐ A knot	☐ Little sore
☐ Numb	☐ Popping	☐ Quick catch	☐ Radiating pain
☐ Sharp	☐ Shooting	☐ Sore	☐ Stabbing
☐ Throbbing	☐ Tight	☐ Tingling	☐ Chronic/Long time

What is the frequency of the symptoms?

☐ Constantly	☐ Frequently	☐ Occasionally	☐ Intermittently
(76-100% of the day)	(51-75% of the day)	(26-50% of the day)	(0-25% of the day)

What makes the pain better?

☐ Acupuncture	☐ Chiropractic	☐ Heat	☐ Ice	☐ Massage
☐ Nothing	☐ NSAIDS	☐ Pain meds	☐ Physical Therapy	☐ Sleep/rest
☐ Stretching	☐ Therapy	☐ Tylenol		

What makes it worse?

☐ Bending	☐ Carry objects	☐ Cleaning	☐ Computer work
☐ Coughing	☐ Crouching/squat	☐ Deep breath	☐ Dressing
☐ Driving	☐ Exercise/sports	☐ Gardening	☐ Getting out of bed
☐ Getting up & down	☐ Going down stairs	☐ Holding objects	☐ Housework
☐ Jogging	☐ Knitting/crocheting	☐ Lifting	☐ Light/sound
☐ Looking up/down	☐ Lying down	☐ Mowing	☐ Personal hygiene
☐ Raising arm	☐ Reaching	☐ Reading	☐ Rolling over in bed
☐ Running	☐ Sewing	☐ Sexual activity	☐ Shopping
☐ Sitting	☐ Standing	☐ Turning	☐ Twisting
☐ Using the phone	☐ Walking	☐ Watching TV	☐ Working
☐ Yardwork			

Next ➡

HEALTH HISTORY

Allergies

☐ NONE	☐ Amoxicillin	☐ Animals	☐ Antihistamine	☐ Aspirin/Pain Meds
☐ Bactrim	☐ Bee stings	☐ Benadryl	☐ Biaxin	☐ Ceclor
☐ Codeine	☐ Dairy Products	☐ Dust	☐ Eggs	☐ Erythromycin
☐ Gluten	☐ Heparin	☐ Hydrocodone	☐ Ibuprofen	☐ Iodine
☐ Latex	☐ Mobic	☐ Molds	☐ Morphine	☐ Motrin
☐ Neurontin	☐ NSAIDS	☐ Nuts	☐ Peanuts	☐ Penicillin
☐ Percocet	☐ Ragweed/Pollen	☐ Red food color	☐ Rubber	☐ Shellfish
☐ Smoke	☐ Soaps	☐ Soy	☐ Sulfa drugs	☐ Tape
☐ Tylenol	☐ Wheat	☐ Other		

Surgeries

☐ NONE	☐ Appendix	☐ Back	☐ Brain/Tumor	☐ Breast
☐ Carpal Tunnel	☐ Disc	☐ EENT	☐ Elbow	☐ Foot
☐ Gastrointestinal	☐ Heart	☐ Hernia	☐ Hip	☐ Hysterectomy
☐ Knee	☐ Lumbar Disc	☐ Neck	☐ Shoulder	☐ Prostate
☐ Tonsils	☐ Wrist	☐ Gallbladder	☐ Bladder	☐ Lung
☐ C-section	☐ Mastectomy	☐ Breast implants	☐ Other	

Medical History

☐ NONE	☐ Alcohol / Drug Abuse	☐ Anemia
☐ Arthritis	☐ Artificial Joints / Implants	☐ Artificial Valves
☐ Asthma/Emphysema	☐ Breathing Difficulties	☐ Broken Bones
☐ Cancer	☐ Chemotherapy	☐ Depression / Other Disorder
☐ Diabetes	☐ Epilepsy / Seizures	☐ Fatigue
☐ Frequent Neck Pain	☐ Headaches	☐ Heart Attack / Stroke
☐ Hepatitis	☐ High Blood Pressure	☐ HIV / AIDS
☐ Kidney Problems	☐ Lower Back Problems	☐ Menstrual Problems
☐ Pacemaker	☐ Parkinson's Disease	☐ Polio
☐ Prostate Problems	☐ Shingles	☐ Tuberculosis
☐ Ulcers/Colitis	☐ Lupus	☐ Gout
☐ Fibromyalgia	☐ Concussion	☐ Psoriasis
☐ Scoliosis	☐ Stroke	

End

Submit