Mager Chiropractic Center

Keeping people healthy and active!

305 Mt Lebanon Blvd., Suite 200
Pittsburgh, PA 15234

Tel (412) 341- 3332
Fax (412) 341 -3370
jmagerdc@comcast.net

PERSONAL INFORMATION

Name: _____ Age:_____ DOB:_____ Sex: M □ F □

Address: _____City/State/ Zip: _____

Home Phone #: (___)_____-_____ Work Phone #: (___)_____-_____

Cell Phone #: (___)_____-_____ Email Address: _____

In case of emergency, which is your preferred method of contact? Home__ Work__Cell__Email__

How did you discover our office?_____ May we send a thank you? Yes □ No □

Status: Single □ Married □ Divorced □ Widowed □ Spouses Name:_____

# of Children _____

Your Occupation: _____ Employer Name: _____

YOUR HEALTH PROFILE

***How can we help you*?** _____
_____

When and how did the problem start? _____
_____

How did it come on? Gradually _____ Suddenly _____

Does this interfere with your: Work ___Leisure ___Sleep___Sports___Other: _____

Have you ever had similar signs / symptoms? Yes □ No □ If yes, when? _____

Which of the following have you seen for this current health problem? Chiropractor ___
Medical Dr.___ Orthopedist ___ Physical Therapist____ Neurologist ____ Other____ None___

During the above visits, was the cause of your health problem identified? Yes □ No □

If yes, what was the diagnosis?_____

What was the recommended solution? _____

GENERAL HISTORY

Have you had any surgeries or hospitalizations? Yes □ No □
Please list all, including your age at the time of hospitalization or surgery:

_____
_____

Do you have a history of major falls/accidents that may have injured your spine? Yes □ No □
If yes, please describe, including your age at the time of the fall or accident(s):

_____
_____

Have you had any fractures, including childhood fractures ? Yes □ No □
If yes, please describe including your age at the time of the fracture (s) : _____
_____

Do you have a history of auto accident (s)? Yes □ No □
If yes, Number of auto accidents: 1 2 3 4 5 >5

What was your approximate age at the time of the of accident(s): _____
How do you describe the accident(s): Minor _____ Moderate _____ Severe:_____
Was care received: Yes □ No □ If yes, Medical doctor__ Orthopedist__ Chiropractor ___
Emergency Room___ Physical Therapy ___ Other _____

Do you have a history of:

<u>Heart Issues</u> (i.e. irregular heartbeat, heart disease): Yes □ No □ Still on medication: Yes □ No □
If yes, **please specify**: _____

<u>Lung Issues</u> (i.e. asthma, COPD): Yes □ No □ Still on medication: Yes □ No □
If yes, **please specify**: _____

<u>Stomach/Digestive Issues</u> (i.e. IBS, constipation): Yes □ No □ Still on medication: Yes □ No □
If yes, **please specify**: _____

***<u>Women Only</u>:** Are you currently pregnant? Yes □ No □ If yes, what is your due date?_____
Do you suffer from menstrual pain? Yes □ No □

YOUR IMMUNITY HEALTH:

Where do you typically store stress? Head _____ Gut _____ Back _____ Skin_____

Do you have a history of joint replacement? Yes □ No □ If yes, what joint (s)_____

Does your family have a history of joint replacements: Yes □ No □ If yes, what joint (s)_____

Do you supplement with vitamin D? Yes □ No □

Are there any common illnesses or diseases in your family? Yes □ No □
If yes, please describe:_____
_____

Because the **Nervous System controls everything in your body**, it is common that current health challenges can be related to the problems you are seeking care for in our office.

Please check (✓) the following symptoms you have had, whether CURRENT (C) or PAST (P):

	C	P		C	P		C	P		C	P
Headaches	☐	☐	Depression	☐	☐	Ulcers	☐	☐	Restless legs	☐	☐
Dizziness	☐	☐	Fatigue	☐	☐	Kidney Stones	☐	☐	Tingling in legs	☐	☐
Buzz/Ringing in ears	☐	☐	Loss of smell	☐	☐	Urinary issues	☐	☐	Cold Feet	☐	☐
Sensitive to light	☐	☐	Loss of taste	☐	☐	Cold hands	☐	☐	Numbness in toes	☐	☐
Loss of balance	☐	☐	Heartburn	☐	☐	Numbness in hands	☐	☐	Seasonal allergies	☐	☐

Is there any history of concussions? Yes ☐ No ☐ If yes, how many? 1 2 3 4 5 >5
If yes, please describe, including your age at time of the concussion(s):_____
_____
_____

Please **RATE** on a scale of 1 to 10 (1 being very poor and 10 being excellent) and **CIRCLE ALL** answers that apply to your sleeping habits:

Sleep: _____ 

- I sleep 7-9 hours per night
- I wake up well rested
- I wake up tired
- I toss and turn
- I stay up late

Are you currently taking any prescription medications? Yes ☐ No ☐
If Yes, please list.

Medication Name	Dosage and Frequency	Reason for Medication

Do you have medication allergies? Yes ☐ No ☐
If Yes, please list medications and reactions:

Medication Name	Reaction	Onset Date	Additional Comments

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature_____ Date: _____
(or Parent/Guardian if patient is under 18 years of age)

Thank you for filling out this form. It is your first step to Creating Wellness!
Present this to our staff and in a moment, we will be starting our journey together!