Welcome to McFarland Chiropractic

Patient Information

Thank you for choosing ***McFarland Chiropractic*** for your chiropractic and healthcare needs. Please complete this form in black ink. If you have any questions or concerns, please do not hesitate to ask us for assistance. We are happy to help. *(please print clearly)*

Name: _____ Social Security #: _____
First Middle Initial Last

Address: _____City: _____State: _____ Zip Code: _____

Sex: ❑ Female ❑ Male Birthdate: _____ Age:____ Email: _____

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partner

Home Phone: (_____)_____Cell Phone: (_____)_____Work Phone: (_____)_____

Do you prefer to receive reminders at: ❑ Home ❑ Work ❑ Cell ❑ Text ❑ Email

Please Circle Your Cell Phone Carrier for us to send you text reminders:

AT&T Verizon Sprint T-Mobile Cingular Boost MetroPCS US Cell Virgin

Patient Employer/School: _____Occupation: _____

Employer/School Address: _____City: _____State: ___ Zip Code: _____

Spouse or parent's name: _____ Employer: _____Work Phone: (_____)_____

How did you hear about us?

❑ Advertisement ❑Attorney ❑ Doctor Referral: _____ ❑ Health Fair
Doctor's Name

❑ Insurance ❑ Internet ❑ Patient Referral _____ ❑ Our Website
Patient's Name

❑ Workshop ❑Other:_____

Person to contact in case of emergency: _____ Phone: (_____)_____

Family Members

Over 70% of our patients bring in their family members to get adjusted. If you would like to have your children, spouse or significant other checked for subluxations, please check the box below. They can each receive a complimentary examination including computerized surface EMG and X-rays (if necessary) if scheduled within two weeks of you starting care. This exam is no cost to you and does not obligate them to receive future care. We have several convenient and affordable family plan payment options should family members decide to receive care. ☐ ***I would like my family members checked for subluxations in the next two weeks.***

Responsible Party ❑ Same as above

Name of person responsible for this account: _____

Relationship to patient: _____Phone: (_____)_____

Address: _____City: _____ State: _____ Zip Code: _____

Name of employer: _____Work Phone: (_____)_____

Insurance Information

(Please present your insurance card to the front desk for us to make a copy)

Insurance Co.: _____ ID Number:_____

❑ **Check here if you are the insured If No, please complete the following:**

Name of insured: _____Relationship to patient: _____

Birthdate: _____ Social Security#: _____

Do you have additional insurance? ❑ Yes ❑ No **If Yes, please complete the following:**

Name of insured: _____ Relationship to patient: _____

Birthdate: _____Social Security#: _____Date employed: _____

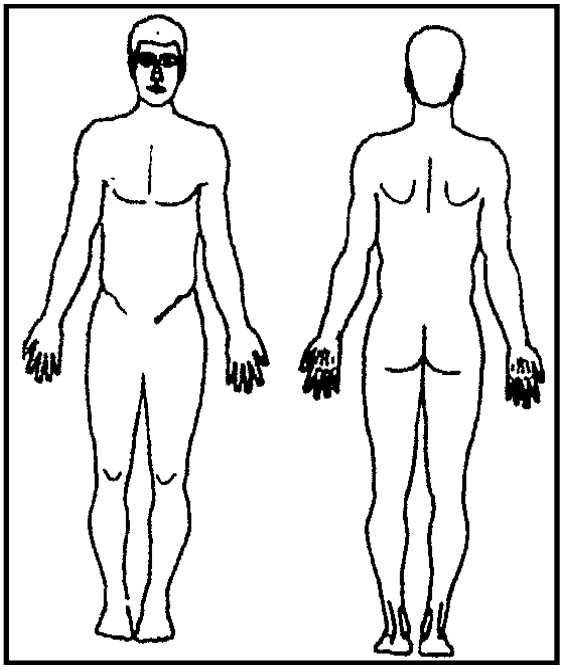
Name of employer: _____ Work Phone: (_____)_____

Address: _____City: _____State: _____ Zip Code: _____

Insurance Co.:_____ ID Number:_____

Symptoms

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



Reason for your visit**:** _____

When did you first notice the symptoms? (Onset Date)_____

How did the problem begin? (Injury/Event)_____

Is the condition getting progressively: ❑better ❑worse ❑staying the same

Where specifically is the problem(s) located? _____

Nature or Type of Pain:

Please write each symptom below and check the nature of the pain for each symptom.

Symptom 1:_____ ❑ Burning Pain ❑ Dull Aching Pain ❑ Numbness ❑Radiating Pain
❑ Sharp Pain ❑ Shooting Pain❑ Tightness ❑ Tingling ❑ Throbbing

Symptom 2:_____ ❑ Burning Pain ❑ Dull Aching Pain ❑ Numbness ❑Radiating Pain
❑ Sharp Pain ❑ Shooting Pain❑ Tightness ❑ Tingling ❑ Throbbing

Symptom 3:_____ ❑ Burning Pain ❑ Dull Aching Pain ❑ Numbness ❑Radiating Pain
❑ Sharp Pain ❑ Shooting Pain❑ Tightness ❑ Tingling ❑ Throbbing

Intensity Level of Pain: (0 = no pain or discomfort, to 10 = severe unbearable pain)

Please write each symptom and circle a number below to rate the severity of your pain for each symptom.

Symptom 1:_____	0	1	2	3	4	5	6	7	8	9	10
	No Pain										Unbearable Pain
Symptom 2:_____	0	1	2	3	4	5	6	7	8	9	10
	No Pain										Unbearable Pain
Symptom 3:_____	0	1	2	3	4	5	6	7	8	9	10
	No Pain										Unbearable Pain

Daily Activities Affected Level:

Please circle a number below to indicate how much your pain or symptoms interferes with your daily activities? (e.g. work, social activities, or household chores)

Symptom 1:_____	0	1	2	3	4	5	6	7	8	9	10
	No Interference										Unable to carry on any activities
Symptom 2:_____	0	1	2	3	4	5	6	7	8	9	10
	No Interference										Unable to carry on any activities
Symptom 3:_____	0	1	2	3	4	5	6	7	8	9	10
	No Interference										Unable to carry on any activities

Frequency of Symptoms:

Symptom 1:_____

❑0-25% (Intermittent) ❑26-50% (Occasional) ❑51-75% (Frequent) ❑76-100% (Constant)

Symptom 2:_____

❑0-25% (Intermittent) ❑26-50% (Occasional) ❑51-75% (Frequent) ❑76-100% (Constant)

Symptom 3:_____

❑0-25% (Intermittent) ❑26-50% (Occasional) ❑51-75% (Frequent) ❑76-100% (Constant)

Which activities are difficult to perform?

❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑Other:_____

What treatment have you received for your condition?

❑Acupuncture ❑Chiropractic ❑Massage ❑Medication ❑ Physical Therapy ❑Surgery

❑ Other: _____

Name and address of other doctor(s) who have treated you for your condition:

_____

Have you had spinal x-rays, MRI, or CT Scan taken for your areas of complaint? ❑ Yes ❑ No

If yes, please list the date and areas taken:_____

Allergies:

_____

List any types of surgeries which you have had and the dates which they occurred:

_____

Please list all medications you are currently taking:

_____

Dates of last exams:

_____

Women: Are you pregnant? ❑Yes ❑No Nursing? ❑Yes ❑No Taking Birth Control Pills? ❑Yes ❑No

Pregnancy Release: This is to certify that to the best of my knowledge that I am not pregnant and McFarland Chiropractic has my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: _____

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Mild❑ Moderate ❑ Heavy

What do your daily work habits include? _____

What vitamins/nutritional supplements do you currently take? _____

Do you smoke? ❑ Yes ❑ No If yes, How much per day?_____

How much alcohol do you consume weekly? _____

How many caffeinated beverages do you consume daily? _____

Personal Health History

Check only those conditions which are applicable:

❑ AIDS/HIV	❑ Chicken Pox	❑ Herniated Disc	❑ Pain at night	❑ Suicide Attempt
❑ Alcoholism	❑ Corticosteroid Use	❑ Herpes	❑ Pain unrelieved by position	❑ Thyroid Problems
❑ Allergy Shots	❑ Depression	❑ High Blood Pressure	❑ Pacemaker	❑ Tonsillitis
❑ Anemia	❑ Diabetes	❑ High Cholesterol	❑ Parkinson's Disease	❑ Tuberculosis
❑ Anorexia	❑ Dizziness/Fainting	❑ Kidney Disease	❑ Pinched Nerve	❑ Tumors, Growths
❑ Appendicitis	❑ Emphysema	❑ Liver Disease	❑ Pneumonia	❑ Typhoid Fever
❑ Arthritis	❑ Epilepsy/Seizures	❑ Measles	❑ Polio	❑ Ulcers
❑ Asthma	❑ Fractures_____	❑ Menstrual Problems	❑ Prostate Problems	❑ Urinary Problems
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraine Headaches	❑ Prosthesis	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Psychiatric Care	❑ Visual Disturbances
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Recent Fever	❑ Venereal Disease
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Rheumatoid Arthritis	❑ Whooping Cough
❑ Cancer	❑ Heart Disease	❑ Mumps	❑ Rheumatic Fever	❑ Abnormal Weight:
❑ Cataracts	❑ Hepatitis	❑ Numbness in Groin/Buttocks	❑ Scarlet Fever _____	❑ Gain ❑Loss
❑ Chemical Dependency	❑ Hernia	❑ Osteoporosis	❑ Stroke (Date)_____	❑ Other _____

Family History

	Mother	Father	Sister 1	Sister 2	Sister 3	Brother 1	Brother 2	Brother 3
Cancer	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑	❑
Rheumatoid Arthritis	❑	❑	❑	❑	❑	❑	❑	❑

	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle
Cancer	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑	❑	❑
Heart Disease	❑	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑	❑
Rheumatoid Arthritis	❑	❑	❑	❑	❑	❑	❑	❑

Review of Systems

Constitutional					
Had	Have		Had	Have	
❑	❑	Fainting	❑	❑	Poor Appetite
❑	❑	Low Libido	❑	❑	Fatigue
❑	❑	Sudden Weight Loss/Gain	❑	❑	Weakness
Eyes					
Had	Have		Had	Have	
❑	❑	Blurry or Double Vision	❑	❑	Specks
❑	❑	Vision Loss	❑	❑	Glaucoma
❑	❑	Glasses or Contacts	❑	❑	Cataracts
Ears, Nose, Throat, Mouth					
Had	Have		Had	Have	
❑	❑	Ringing in Ears	❑	❑	Loss of Taste
❑	❑	Hearing Loss	❑	❑	Loss of Smell
❑	❑	Chronic Ear Infections	❑	❑	Sinus Pain
❑	❑	Sore Throat	❑	❑	Hoarseness
❑	❑	Earache	❑	❑	Dry Mouth
Cardiovascular					
Had	Have		Had	Have	
❑	❑	High Blood Pressure	❑	❑	Chest Tightness
❑	❑	Low Blood Pressure	❑	❑	Chest Palpitations
❑	❑	Chest Pain or Discomfort	❑	❑	Shortness of Breath
❑	❑	High Cholesterol	❑	❑	Poor Circulation
Respiratory					
Had	Have		Had	Have	
❑	❑	Asthma	❑	❑	Emphysema
❑	❑	Apnea	❑	❑	Wheezing
❑	❑	Shortness of Breath	❑	❑	Pneumona
❑	❑	Cough	❑	❑	Sputum
Gastrointestinal					
Had	Have		Had	Have	
❑	❑	Anorexa	❑	❑	Food Sensitivities
❑	❑	Bulimia	❑	❑	Heartburn
❑	❑	Ulcers	❑	❑	Constipation
❑	❑	Acid Reflux	❑	❑	Diarrhea
❑	❑	Rectal Bleeding	❑	❑	Swallowing Difficulties
Genitourinary					
Had	Have		Had	Have	
❑	❑	Frequency	❑	❑	Urgerncy
❑	❑	Blood in Urine	❑	❑	Burning Pain
❑	❑	Incontinence	❑	❑	Change in Urinary Strength
Musculoskeletal					
Had	Have		Had	Have	
❑	❑	Osteoporosis	❑	❑	Arthritis
❑	❑	Knee Injuries	❑	❑	Foot/Ankle Pain
❑	❑	Scoliosis	❑	❑	Neck Pain
❑	❑	Shoulder Problems	❑	❑	Elbow/Wrist Pain
❑	❑	Back Problems	❑	❑	Hip Disorders
❑	❑	TMJ Issues	❑	❑	Poor Posture

Integumentrary					
Had	Have		Had	Have	
❑	❑	Skin Cancer	❑	❑	Hair Loss
❑	❑	Eczema	❑	❑	Rash
❑	❑	Acne	❑	❑	Psoriasis
Neurological					
Had	Have		Had	Have	
❑	❑	Headache	❑	❑	Dizziness
❑	❑	Pins & Needles	❑	❑	Numbness
❑	❑	Seizures	❑	❑	Tremor
Psychiatric					
Had	Have		Had	Have	
❑	❑	Nervous/Anxiety	❑	❑	Depression
❑	❑	Stressed	❑	❑	Memory Loss
Endocrine					
Had	Have		Had	Have	
❑	❑	Heat or Cold Intolerance	❑	❑	Frequent Urination
❑	❑	Sweating	❑	❑	Excessive Thirst
Hematologic/Lymphatic					
Had	Have		Had	Have	
❑	❑	Ease of Brusing	❑	❑	Ease of Bleeding
Allergic/Immunologic					
Had	Have		Had	Have	
❑	❑	Hay Fever	❑	❑	AIDS
❑	❑	HIV Positive	❑	❑	Tuberculosis
❑	❑	Herpes	❑	❑	Syphilis
❑	❑	Staphylococcus Infection	❑	❑	Viral Infection
❑	❑	Bacterial Infection	❑	❑	Streptococcus Infection

Certification

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a healthcare benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I or my minor child have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Plans may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor and/or ASH Plans to contact my physician, if necessary.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Assignment of Benefits and Responsibility of Payment

I herby instruct the _____ insurance co. to pay by check made out to and mailed directly to:

McFarland Chiropractic
Dr. Lorne S. McFarland, D.C.
17660 Yorba Linda Blvd.
Yorba Linda, CA 92886

If my current policy prohibits direct payments to the doctor, then I herby also instruct and direct you to make out the check to me and mail it directly to:

McFarland Chiropractic
Dr. Lorne S. McFarland, D.C.
17660 Yorba Linda Blvd.
Yorba Linda, CA 92886

For the professional or medial expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a **direct assignment of my rights and benefits under this policy.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in current manner any balance, deductable, and/or co-pay of said professional service charges over and above this insurance payment.
I further understand that I will be responsible for the payment to any other facilities and /or healthcare providers that I may be referred to by ***McFarland Chiropractic or above mentioned doctor*** and any emergency transporting that may be required thereto. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in the case.

This office will gladly prepare insurance forms and reports; however, we cannot render services on the assumption that our charges will be paid by the insurance company or attorney settlement. All professional services are charged directly to the patient, therefore basic responsibility for payment is yours.

_____(INTIAL) I Herby acknowledge and understand that in the event that I do not have insurance that covers chiropractic services or products that all services and products are payable when treatment is rendered and that basic responsibility for payment is mine. I further understand that if I am delinquent on my obligation to pay ***McFarland Chiropractic*** that I will be responsible for any late fees, interest charges, court cost, attorney fees, and collection charges should the balance not be paid in due diligence.

Name:_____Birthdate:_____

Social Security # :_____ _____ Driver License #:_____

_____ _____
Patient, Parent, or Guardian Signature Date

Informed Consent For Chiropractic Care

I herby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, physiotherapy modalities, therapeutic massage, nutritional/diet counseling and diagnostic x-rays, and supportive therapies on me (or on the patient named below, for whom I am legally responsible) by ***McFarland Chiropractic*** and the doctor of chiropractic indicated below and/or other licensed doctor's of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand the results are not guaranteed. I understand and am informed that, as in the practice of medicine and like other health modalities, results are not guaranteed, and there is not promise of cure. I further understand and am informed that as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure in which the doctor feels at the time, based on the facts then know, is in my best interests. I further understand that there are treatment options available for my condition other than chiropractic procedures. I understand and have been informed that I have the right to a second opinion and to secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above –named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

McFarland Chiropractic
Dr. Lorne S. McFarland, D.C.

_____ _____

PATIENT'S NAME (PLEASE PRINT) DATE

_____

SIGNATURE OF PATIENT (OR GUARDIAN IF PATIENT IS A MINOR)

(PLEASE COMPLETE THE INFORMATION ON THE NEXT PAGE IF THE PATIENT IS A MINOR)

Consent to Treatment Of a Minor

Name of responsible party: _____Social Security #:___ ___ _____

Relationship to minor: ❑ Father ❑Mother ❑Other_____

Address of responsible party:_____

Home phone: _____ Cell phone: _____

Responsible party employed by: _____Work phone:_____

Employer address: _____City:_____ Zip:_____

I being the parent or guardian of _____, a minor, the age of _____ do herby consent , authorize and request ***McFarland Chiropractic*** to administer such treatment deemed advisable, necessary or requested on the above minor. I (We) agree to hold ***McFarland Chiropractic*** free and harmless from any claims, suites for damages or complication which may result for such treatments.

_____ _____

DATE SIGNATURE OF PARENT/GUARDIAN

_____ _____

DATE SIGNATURE OF WITNESS