MacKay Chiropractic, LTD., 7450 W. Cheyenne Ave. #114 Las Vegas, NV 89129 (702)655-2999

Date_____ Patient #_____

Personal History

Name:_____ Address: _____
City: _____ State: _____ Postal Code: _____
Birth date:_____ Age: _____ Sex: ☐ M ☐ F
Home Phone: _____ Cell Phone: _____
Social Security #: _____ Type of Work_____
Email (for appt/e-news letter): _____
Business/Employer: _____ Business Phone: _____
Circle One: Married Single Widowed Divorced Separated Other Number of Children: _____
Emergency Contact:_____ Phone Number: _____ Relationship: _____
Whom may we thank for referring you to this office?_____
Who is responsible for your bill: ___You ___Worker's Comp ___Auto Insurance ____Medical Insurance
How will you be paying your account? ☐Credit Card ☐Cash ☐Check ☐Insurance ☐Other_____

Current Health Condition

Current Complaint(s):_____
Other doctors seen for this condition? ☐ Yes ☐ No Who? _____
Type of Treatment:_____ Results: _____
When did this condition begin? _____ Has the condition occurred before? ☐ Yes ☐ No
Is the condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐ Other:_____
Date of Accident: _____ Time of Accident: _____
What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Down ☐ Cold ☐ Dampness ☐ Other:_____
What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: _____
Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better
Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning
☐ Constant ☐ Intermittent
Please describe how it feels when this problem is at its worse: _____
Place an X on the grade to indicate the severity of your pain: _____

LEAST 1 2 3 4 5 6 7 8 9 10 *WORST*

Compare this problem at its worst and a time when you feel great. How does this problem interfere with:
Your ability to work?_____
Your ability to enjoy your family or your social time?_____
Your ability to enjoy your hobbies or sports?_____
If you don't get the problem corrected, do you think it will get worse over the next 5 years? ☐ Yes ☐ No
Drugs you take now: ☐ Nerve Pills ☐ Painkillers/Muscle Relaxers ☐ Blood Pressure Medicine
☐ Insulin ☐ Other: _____
Do you suffer from any other condition than the one you are now consulting us for?_____
_____
Have you had X-rays taken in the last six months? ☐ Yes ☐ No If yes, where?_____

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Past Health History

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery
☐ Broken Bones ☐ Other: _____

Previous: Childhood Traumas ☐ _____ Sports Injuries ☐ _____
Motor Vehicle Accidents ☐ _____ Work Injuries ☐ _____

Hospitalization (other than above): _____

_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name: _____
Approximate Date of Last Visit: _____

Family Health History

Name of Family Physician: _____

Please indicate any health issues that are present in your family:

Parents: _____

Siblings: _____

Does any member of your family suffer from the same condition? ☐ No ☐ Yes Whom? _____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.
Check any of the following you have had in the past six months:

Nervous System
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Stress

Musculo-Skeletal
- ☐ Low Back Pain
- ☐ Gas/Bloating After Meals
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Black/Bloody Stool
- ☐ Arm Pain
- ☐ Colitis
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

General
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Gastro-Intestinal
- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

Male / Female
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction

Genito-Urinary
- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine

When was your last period?

_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

Intake

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

Satisfaction with Diet

- ☐ Highly Satisfied
- ☐ Dissatisfied
- ☐ Highly Dissatisfied

Do you have a regular exercise program?

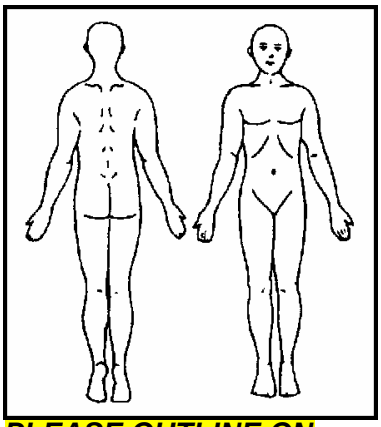
- ☐ Yes
- ☐ No

Lifestyle Stress Levels

- ☐ High
- ☐ Moderate
- ☐ Very Little

Check any of the following diseases you have had:

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



PLEASE OUTLINE ON THE DIAGRAM, THE AREA OF YOUR DISCOMFORT AND ANY RADIATION OF PAIN

Please Read Carefully:

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 necessary reports and forms to assist me in making collection from the insurance and 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 my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic and / or anyone working in this clinic authorized by the doctor of chiropractic.

I have had an opportunity to discuss with the doctor of chiropractic / staff member and / or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, rib fractures, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure that the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read and understood the above and I consent to all examinations and care as deemed appropriate by the Doctor of Chiropractic for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the Doctor either before or after I sign this consent, and I understand that my consent can be withdrawn at any time.

_____ _____

Patient Signature Date

Signature on File

Please **Initial** then **Sign** below. Thank You.

_____I authorize use of this form on all my insurance submissions.

_____I authorize release of information to all my Insurance companies.

_____I understand that ***I am*** responsible for my bill.

_____I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

_____I authorize payment direct to my doctor.

_____I permit a copy of this authorization to be used in place of the original.

Your insurance policy is a contract between you and your insurance company. All fees are your responsibility. We bill your insurance as a courtesy.

Name_____ Medicare#_____
Please Print if applicable

Signature_____ Date_____

Health Care Authorization Form

Patient's Name _____
Patient's SS #_____Date of Birth_____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **Mackay Chiropractic** TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING: **PLEASE INITIAL BELOW**

SPECIFIC AUTHORIZATIONS

____ I give permission to **Mackay Chiropractic, LTD.** to verify my insurance, use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, testimonials, patient photographs, newsletters, birthday cards, holiday related cards information about treatment alternatives or other health related information.

____ If **Mackay Chiropractic, LTD.** contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

____ I give permission to **MacKay Chiropractic, LTD**, to use my **email / phone** for:
(circle one or both)
___appointment reminders ____e-news newsletter

____ By signing this form you are giving **Mackay Chiropractic, LTD.** permission to use and disclose your protected health information in accordance with the directives listed above.

EXPIRATION

The Authorization shall expire on the following date: Indefinite

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **Mackay Chiropractic, LTD.** The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;

The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

The AUTHORIZATION is requested by Mackay Chiropractic for its own use/disclosure of PHI. *(Minimum necessary standards apply)*

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **Mackay Chiropractic, LTD.** will not refuse to provide treatment.

You have the right to inspect or copy PHI to be used/disclosed.

A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON YOUR REQUEST

Print Name of Patient_____

Signature of
Patient_____Date_____

Signature of Personal Representative_____

Description of Representative's Authority to Act for Patient:_____

_____

_____ I have read and received the "Notice of Privacy Practices for Protected
(Initial) Health Information."