McGlynn Chiropractic
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Neck & Back Pain Assessment

First Name: _____Last Name:_____

Address: _____

City: _____ State: _____ Zip:_____

Preferred phone: _____(cell or home?) Alt. Phone:_____(cell or home?)

Date of Birth: _____/_____/_____ Age: _____ Sex: M / F Marital Status:_____

Children/Ages:_____Occupation:_____How long:_____

Referred by: _____Primary Physician:_____Phone:_____

*Email Address:_____

*(Required: Appointment reminders delivered via email)

The practitioners at McGlynn Chiropractic work in collaboration with each other in order to provide optimal care. I give permission for the practitioners working with me to communicate with each other about my healthcare needs and treatment plans. _____
Initial here

I, the undersigned, being of sound mind and exercising my freedom of choice, openly accept responsibility for my healthcare choices. I understand that services received at McGlynn Chiropractic do not need to be a substitute for medical treatment and instead, can often be used to complement other treatments. _____
Initial here

I agree to keep my practitioners and my records updated as to changes in my life and medical needs. _____
Initial here

We understand that unanticipated events happen occasionally in everyone's life. business meetings, project deadlines, flight delays, car problems, snowstorms, and illness are just a few reasons why one might consider canceling an appointment. In our desire to be effective and fair to all of our clients and out of consideration for our therapists' time, we have the following policies:

- **24 hour advance notice is required** when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment.
- If you are unable to give us 24 hours advance notice you will be charged **$25/$50 respectively**. This amount must be paid prior to your next scheduled appointment.

Arriving late

Appointment times have been arranged specifically for you. If you arrive late your session may be shortened in order to accommodate others who appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the full session.

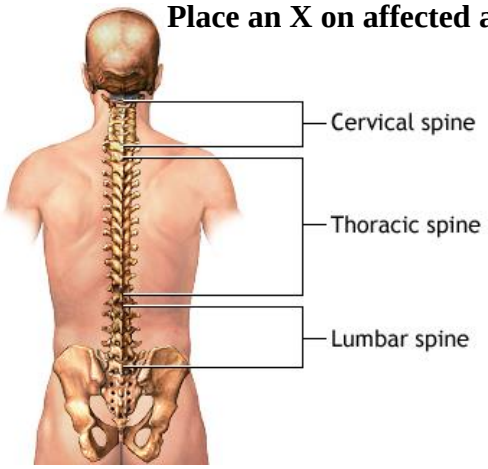
Signature:_____ Date:_____

Overall health (circle one): Excellent / Good / Fair / Poor / Other:_____

Chief complaint (reason you are here)(Grade your pain Less pain 0-10>Pain):_____

_____

Place an X on affected area



What makes it better: _____

Worse: _____

Does it radiate: _____

Does it: Throb Ache Cramp **Is it:** Shooting Dull Sharp Numb

Amount of time affected: 1/4 1/2 All Day

Activities affected: Self-care_____ Work_____ Homecare_____

Hobby_____ Physical limits_____ Cognitive_____

Diet: Do you..?
- ☐ have dietary preferences
- ☐ have dietary restrictions
- ☐ crave particular foods
- ☐ have a particular diet

Substance intake: Do you..?
- ☐ drink caffeine AMT_____
- ☐ smoke AMT_____
- ☐ drink alcohol AMT_____
- ☐ drink water AMT_____

Sleep: Do you..?
- ☐ sleep soundly
- ☐ trouble falling asleep

Exercise: Do you…?
- ☐ exercise regularly
- ☐ have energy

Medications/Vitamins/Dates:

Injuries/Surgeries/Dates:

_____

_____

_____

_____

General:
Anxiety
Depression
Dizziness
Fatigue
Forgetfulness
Headache
Head injury

Muscle, Joint, Bone:
Pain, Weakness, Numbness in:
Arms
Backs
Feet
Hands
Hips
Legs
Neck
Shoulder

Cardiovascular:
High blood pressure
Low blood pressure
Poor circulation
Swelling of ankles

Allergies to:
Animals
Environmental
Food
Medication
Other

Women Only:
Pregnant

Conditions: (S=Self F=Family B=Both)

☐ Alcoholism	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia
☐ Anemia	☐ Eating disorders	☐ Kidney disease	☐ Prostate
☐ Arthritis	☐ Emphysema	☐ Liver disease	☐ Scoliosis
☐ Asthma	☐ Gum Disease	☐ Migraine headaches	☐ Seizures
☐ Bronchitis	☐ Heart Disease	☐ Miscarriage	☐ Thyroid problems
☐ Cancer	☐ Hepatitis	☐ Mononucleosis	☐ Ulcers
☐ Chemical Dependency	☐ Herpes	☐ Multiple Sclerosis	☐ **Other**

Signature:_____ Date:_____