Piscataway Chiropractic Center

Dr. Mark McKenna D.C.

Today's Date_____Date of Birth_____

Name_____

Address_____

City_____State____Zip_____

Phone Number_____

E-Mail Address_____

Occupation: _____Employer_____

Height_____Weight_____Sex_____

Marital Status_____Name of Spouse_____

How did you hear about us? _____

Previous chiropractic care? Y____N___For what?_____

Were the results satisfactory? Y_____N_____N/A_____

Main complaint today?_____

_____

How and when did this begin?_____

_____

Have you lost any work from this?_____

Have you ever had this before?_____

When?_____

What aggravates the complaint?_____

_____

What helps your complaint?_____

_____

Have you tried anything for it? (Heat/Ice/NSAIDS/etc)____

If so, what have you tried?_____

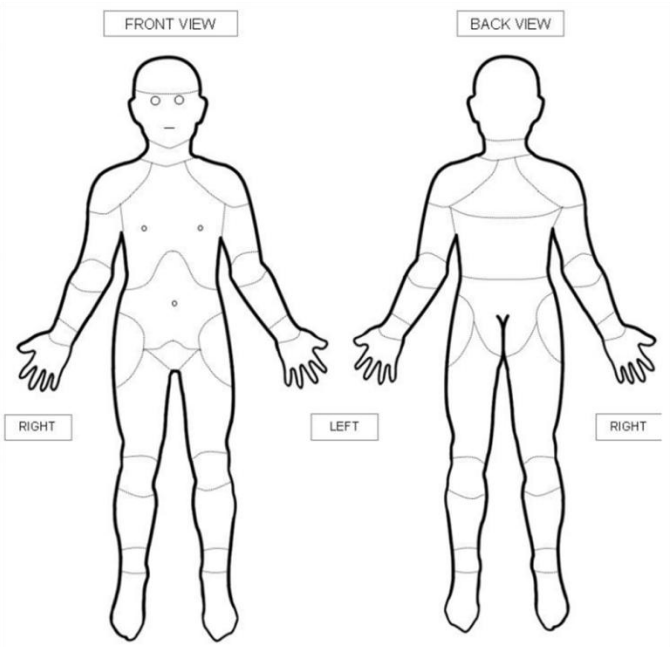
_____

Have you been treated for this in the past?_____

If so, where?_____

Describe the type of treatment_____

Please indicate where the complaint is on the diagram:



Aching_____Burning_____Numb_____Tingling_____

Sharp_____Shooting_____Stabbing_____Other_____

Family physician's name_____

Will this case be covered by any insurance company?_____

Major Medical____Auto____Workers' Compensation_____

Medicare_____Other_____

Who is responsible for this account?_____

Relationship to the account holder?_____

Date of birth of the account holder?_____

Any recent accidents?_____

Any past accidents?_____

When?_____

Any allergies?_____

Current prescriptions_____

_____

_____

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Any past broken bones?_____

When?_____

Past dislocations?_____

When?_____

Any previous operations?(Please give year)_____

_____

_____

Please give approximate dates of most recent: MRI_____

Blood Tests____CT Scan____Ultrasound____Urinalysis____

Radiation Treatment_____X-Ray Exam_____Other_____

Where were these taken?_____

Are you currently pregnant?Y_____N_____

Do you exercise regularly? Y____N____How often?_____

What kind of exercise?_____

Tobacco use?Y____N____Quantity_____

Alcohol use?Y____N____Quantity_____

Caffeine use?Y____N____Quantity_____

Supplements?Y____N____Type_____

_____

Vitamins?Y____N____Type_____

Have you lost or gained weight in the last 12 months?_____

About how many pounds?_____

Please check any of the following that are applicable

Headaches		Anxiety		Sensitivity to Lights	
Back Pain		Depression		Ringing in Ears	
Neck Pain		Trouble Sleeping		Loss of Memory	
Stiff Neck		Nervousness		Loss of Smell	
Numbness in Arms/Hands		Irritability		Loss of Taste	
Pins & Needles in Arms/Hands		Chest Pain		Fainting	
Weakness in Arms/Hands		Shoulder Pain		Arthritis	
Numbness in Legs/Feet		Shortness of Breath		Fever	
Pins & Needles in Legs/Feet		High Blood Pressure		Nausea/Diarrhea	
Weakness in Legs/Feet		Fatigue		Constipation	
Muscle Spasms		Diabetes		Menstrual Difficulties	
Swelling Joints		Difficulty Urinating		COVID-19	

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with

_____ (name of insurance company) and assign directly to

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my healthcare information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits for the patients payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed.

Patient Signature _____

Date of Signature_____

Parent/Guardian Signature_____

Relationship to Patient_____