KENNETH P. MADORE, DC

PATIENT INFORMATION

PATIENT NAME:

Last Name:_____ First Name:_____ Middle:_____

Gender: Male ◯ Female ◯ Date of Birth:_____/_____/_____ Age:_____

Home Address:_____

City:_____ State:_____

Zip:_____

Home Phone:_____ Cell Phone:_____

Personal Email:_____

Employer Name:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

SPOUSE OR GUARDIAN

Last Name:_____ First:_____ Middle:_____

Employer Name:_____ Phone:_____

Date of Birth:_____/_____/_____

EMERGENCY: *Name and address of nearest relative or friend not living with you.*

Last Name:_____ First:_____ Middle:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

Relation to Patient:_____

PAYMENT METHOD: *For all services that are not paid by a third party (Insurance, Medicare, Medicaid)*

Cash ◯ Check ◯ Visa ◯ Mastercard ◯ Discover ◯ American Express ◯

If you have any insurance coverage that might pay a portion of your financial obligations, please ask about our policy.

MY CERTIFICATION

I certify that the above information is correct and I request services

*X*_____

Signature of patient acting on patient's belalf ***Date***

KENNETH P. MADORE, DC
MEDICAL *and* HEALTH HISTORY

PATIENT NAME:

Date:_____ Patient Name:_____ Date of Birth:_____

MAIN PROBLEM

What pain causes you to come to the office?_____

What caused this pain?_____

When did this pain start?_____

How long does this pain usually last?_____

How bad is this pain? (Circle one - 1= mild pain - 10 = intense pain)

1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯

Circle the word or words that best describe the pain:

Cramping◯ Aching◯ Dull◯ Sharp◯ Shooting◯ Bright◯ Diffuse◯

Lightning-Like◯ Throbbing◯ Nagging◯ Burning◯ Deep◯ Stinging◯ Pressure-Like◯

How often does this pain occur? (Circle One) Occasional Frequent Constant

Does this pain travel to any other area?_____

What makes this pain better?_____

What makes this pain worse?_____

Are there other symptoms that occur with the pain? Stiffness, weakness, cramping-muscle spasms, swelling, other?

_____

What else have you done to treat this pain?

Ice Packs◯ Heating Pads◯ Hot Showers◯ Rest◯ Over-The-Counter Pain Meds◯ Other:

_____

OTHER PROBLEM

Do you have another problem or other pain?_____

What caused this pain/problem?_____

When did this pain/problem start?_____

How long does this pain last?_____

How bad is this pain? (Select One - 1 = mild pain - 10 = intense pain)

1◯ 2◯ 3◯ 4◯ 5◯ 6◯ 7◯ 8◯ 9◯ 10◯

Circle the word or words that best describe the pain:

Cramping◯ Aching◯ Dull◯ Sharp◯ Shooting◯ Bright◯ Diffuse◯

Lightning-Like◯ Throbbing◯ Nagging◯ Burning◯ Deep◯ Stinging◯ Pressure-Like◯

How often does this pain/problem occur? (Select One) Occasional◯ Frequent◯ Constant◯

Does this pain travel to any other area?_____

KENNETH P. MADORE, DC
MEDICAL *and* HEALTH HISTORY (continued)

What makes this pain better? _____

What makes this pain worse? _____

What else have you done to treat this pain?

Ice Packs ◯ Heating Pads ◯ Hot Showers ◯ Rest ◯ Over - The - Counter Pain Meds ◯

Other: _____

Are there other problems you would like to discuss today? _____

_____

OTHER HISTORY

Do you smoke? Yes ◯ No ◯ If yes, how many per day? _____

Do you drink? Yes ◯ No ◯ If yes, how much? _____

Do you exercise regularly? Yes ◯ No ◯ If yes, how often? _____

Are you pregnant? Yes ◯ No ◯ Date of last physical exam _____

Are you employed? Yes ◯ No ◯ Where? _____

How would you rate your daily amount of stress (select one)

Low/None ◯ Moderate ◯ High ◯ Extremely High ◯

Do you have children? No ◯ Yes ◯ If yes how many? _____ Youngest Age: _____ # at home: _____

Are you married? Yes ◯ No ◯ Status: Never ◯ Separated ◯ Divorced ◯ Spouse ◯ Deceased ◯

How is your overall health? _____

List past illnesses: _____

_____

Does your family have serious medical problems that appear to be inherited, i.e. "that run in your family?"

No Yes Describe: _____

_____

Surgeries/Hospitalizations/ Injuries: _____

_____

Medications - Purpose: _____

_____

PRIVACY PROTECTION:

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: plan, coordinate, and direct m treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third party payors; Conduct normal healthcare operations such as quality assessments and accrediation.

x _____ Date: _____

Signature of patient or person acting on patient's behalf