

**Kenneth P. Madore, D.C.**

**PATIENT INFORMATION**

**PATIENT NAME:**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Gender: Male  Female  Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_

SS# \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Personal Email: \_\_\_\_\_

Employer Name \_\_\_\_\_ Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**SPOUSE or GUARDIAN:**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Employer Name \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_

**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 or person acting on patient's behalf*

*Date*

# Kenneth P. Madore, D.C.

## MEDICAL and HEALTH HISTORY

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

Lightening-like  Throbbing  Nagging  Burning  Deep  Stinging  Pressure-like

How often does the 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/problems 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

Select the word or words that best describe the pain:

Cramping  Aching  Dull  Sharp  Shooting  Bright  Diffuse

Lightening-like  Throbbing  Nagging  Burning Deep  Stinging  Pressure-like

How often does the pain/problem occur? (Select one) Occasional  Frequent  Constant

Does this pain travel to any other area? \_\_\_\_\_

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 is: \_\_\_\_\_ # 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**

*(Use other side if necessary)*

**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 my 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 accreditation.

x \_\_\_\_\_ Date \_\_\_\_\_

*Signature of patient or person acting on patient's behalf*