KENNETH P MADORE, DC

PATIENT INFORMATION

PATIENT NAME:

Last Name _____ First _____ Middle _____

Gender: Male ○ Female ○ Date of Birth ____ / ____ / ____ Age _____

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 ____ / ____ / ____

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, DC

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