

McCANN CHIROPRACTIC CENTER

Welcome

Daniel J. McCann, D.C.

*Practice Limited to
the Treatment of
Neuro-musculo-skeletal
Conditions*

The doctor and staff of the McCann Chiropractic Center welcomes you and wants to provide you with the best care possible. We will conduct a thorough history and physical examination to decide if we can assist you. If your condition is one that will not respond to chiropractic care, you will not be accepted as a patient and referred to another health care provider.

Patient Identification:

Name: _____

Address: _____

Telephone: Home _____ Work: _____

Spinal manipulation therapy

OK to call there? Yes () No ()

Social Security Number: _____ Male () Female ()

Date of Birth: _____ Marital Status: Single () Married ()

Age: _____ Divorced () Widow ()

Height _____ Weight _____

Contact Name in Case of Emergency: (Name) _____

Adjunctive procedures

Telephone # _____ Name of Parent/Guardian(if minor) _____

Is your condition due to a Work Injury or Auto Accident Yes () No ()

If yes please explain _____

Acceptance as Patient:

Spinal rehabilitation

I understand and agree that McCann Chiropractic Center has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of gathering information so that the doctor can determine whether to accept me as a patient.

5 Brookwood Avenue
Carlisle, PA 17013

voice 717-258-5834
fax 717-258-4771
email DMcCannDC@aol.com

Date: _____ Signature: _____

*Integrating chiropractic and exercise
rehabilitation for the treatment of
neck and back pain.*

Patient name: _____

CURRENT CONDITION:

What is your chief complaint or the main reason you have presented to the office? _____

When did it begin? _____

Have you seen any other physician for this complaint? If so, who and when _____

Has the condition disabled you from work? _____ If so, give dates _____

What have you tried to help you with the pain? _____

Has it helped? _____

On a scale of 1-10, place an X in your current pain level you are feeling right now:

NORMAL	LOW PAIN	MODERATE PAIN	INTENSE PAIN	EMERGENCY
() 0	() 1	() 4	() 7	() 10
	() 2	() 5	() 8	
	() 3	() 6	() 9	

On that same scale, how would your pain rate when it is at its worst (use a number) _____

On that same scale, how would you rate your **average** pain level: (use a number) _____

HEALTH HISTORY:

Have you experienced any of the following symptoms:

1. Unexplained weight loss () Yes () No _____
2. Pain/difficulty or lack of control of bladder or bowel function () Yes () No _____
3. Diagnosed with cancer () Yes () No : If yes what kind _____
4. Had a recent infection/ fever (last 3 months) () Yes () No _____
5. Have been diagnosed with lupus, rheumatoid arthritis, osteoporosis, osteoarthritis or gout () Yes () No _____
6. Increased night pain , not relieved with rest () Yes () No _____
7. Have you been diagnosed with high blood pressure, cardiovascular disease or had a stroke? () Yes () No _____
8. Have you been diagnosed with diabetes ? () Yes () No _____

Additional Comments (Do not complete: For the Doctor) _____

Date: _____

Signature _____

Patient Name: _____

Medical Testing:

1. Have you had any diagnostic work done for this condition (MRI, CAT Scan, xray, blood work, nerve conduction, etc.) Yes No If yes, please list the procedure and dates:

2. Are you currently taking any medication, prescription or over the counter (Tylenol, Advil) vitamin supplement or herbs? Yes No If yes please list _____

3. Please list any operations that you have had: _____

4. Is acceptable to send copies of your reports/ findings if necessary to your family physician? Yes No If yes, please list you family doctor _____

Family History

1. Please list any significant health conditions of your immediate family (i.e. diabetes, heart attack, cancer etc.) _____

General Health

1. Do you smoke or chew tobacco? Yes No If yes, how much _____
2. Do you use alcohol? Yes No If yes, how much _____
3. Which of the following describes your diet? good average poor _____
4. Do you have a pacemaker, transplanted organ or metal implant? Yes No _____
5. For female patients, is there any chance that you may be pregnant? Yes No _____

Insurance Information:

Patient Name: _____ Spouse Name: _____

Patient SS#: _____ Spouse SS#: _____

Patient employer: _____ Spouse Employer: _____

Billing: () Cash () Medicare () Workers Compensation () Auto

Insurance: () Blue Cross/Blue Shield () Physicians Care () Penn State/Geisenger

() Other _____ Spouse Date of Birth - _____

How were you referred to the office: () Sprint Yellow Pages () Friend _____

() Sign/Location () Medical doctor/ Health Care Professional _____

() Other _____

Type of care :

Why chiropractic? People choose chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (RELIEF CARE). Others are interested in having the cause of their problems as well as the symptoms corrected and relieved (CORRECTIVE CARE). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (PREVENTATIVE CARE). These are the three phases of care. The doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three phases.

Please check the type of care desired so that we may be guided by your wishes:

() RELIEF CARE () CORRECTIVE CARE () PREVENTATIVE CARE

() Check here if you want the doctor to select the most appropriate care for you.

The staff of the McCann Chiropractic Center will do everything it can to help with the reimbursement for the services provided including: verifying your coverage and submitting the forms for you. Please understand that no insurance attempts to cover all costs. It is your responsibility to pay any deductible or copayment not covered by your policy. I agree to authorize the release of my medical records necessary on my behalf for insurance reimbursement.

I understand that I am personally responsible to give to the doctor any payment made directly to me, for whatever reason, if payment is not made to the doctor instead. If I suspend or terminate care at this office, any outstanding charges for professional services will be immediately due and payable. In addition, I will be responsible to pay any legal fees necessary for any account balance delinquency on my behalf.

Date: _____

Signature: _____

INFORMED CONSENT

After reviewing your health history, the Doctor will examine you and may require other diagnostic tests, such as X-rays, MRI or Lab tests, to make an accurate diagnosis and treatment plan. The Doctor will select a treatment plan which best suits your needs. You will be informed of all alternative treatments available to you. Occasionally the plan may have to be altered during treatment, due to unexpected changes. We encourage you to ask the Doctor any questions you may have so you fully understand your condition.

At this time, we would like to inform you of the risks that may occur from Chiropractic treatment. They are as follows: muscle soreness and irritation, headache, pain, muscle spasm and stiffness. In rare instances, dizziness and/or nausea may occur.

If there is anything you do not understand, please discuss it with the Doctor before signing the statement below.

I certify the information I provided for the health history is true and factual to the best of my knowledge. I understand the office policy and the risks of chiropractic treatment, which were supplied in the statement above. Any additional information which may occur will be supplied to you. I hereby consent to chiropractic treatment.

(Patient's Signature)

(Date)

The patient is unable to consent because _____
(i.e. underage, etc.) I, therefore, consent for the patient.

(Signature)

(Date)

Relationship to patient: _____

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

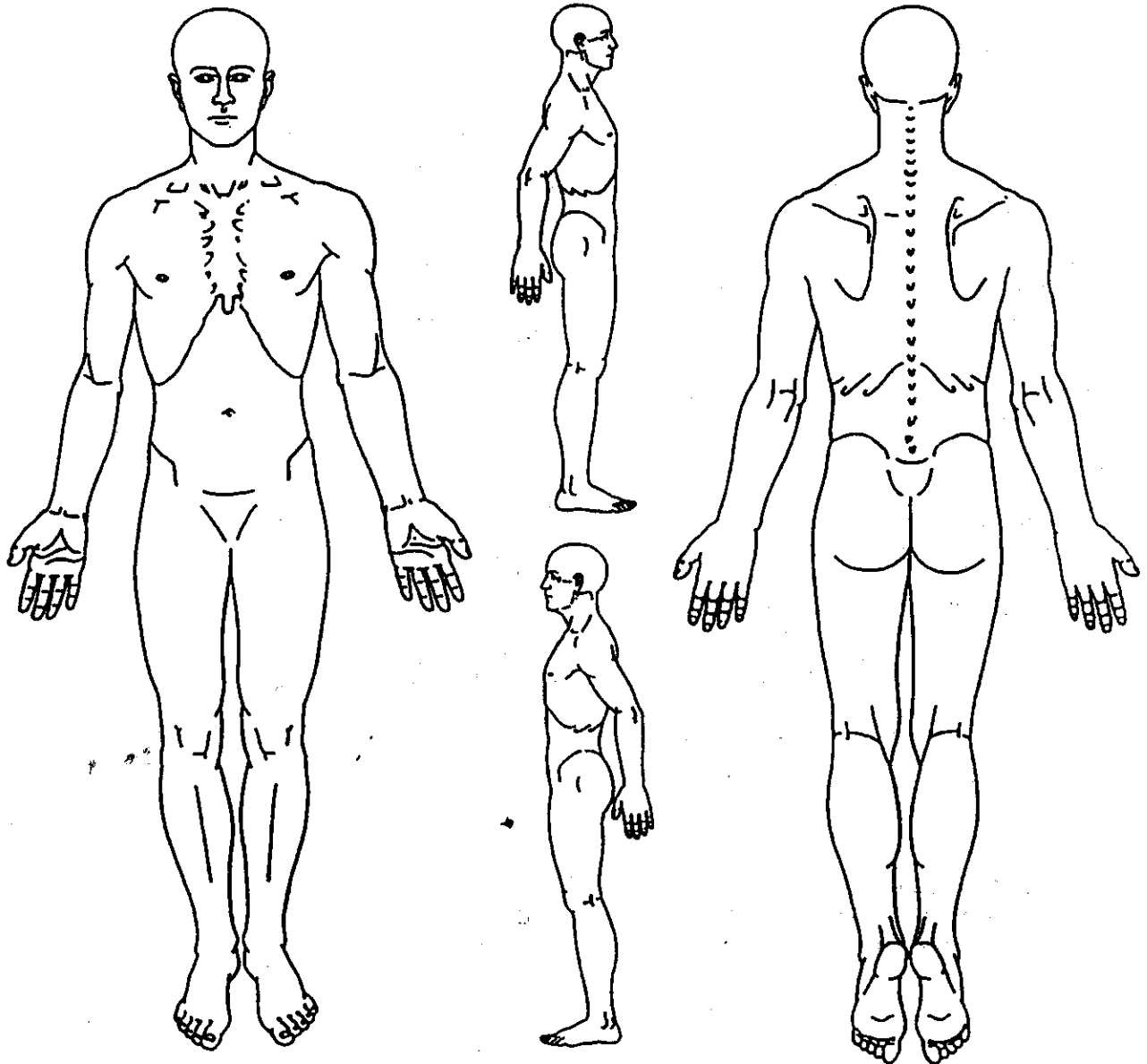
HOW LONG HAVE YOU HAD LOW BACK PAIN? _____ YEARS _____ MONTHS _____ WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? _____ YES _____ NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY: A=ACHE B=BURNING N=NUMBNESS
 P=PINS & NEEDLES S=STABBING O=OTHER



OVER PLEASE