Dr. Thomas McKay *Chiropractic Physician*

SANDHILLS ALTERNATIVE HEALTHCARE

120 WEST VERMONT AVENUE
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Phone: 910-693-3700 Fax: 910-693-3709
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PATIENT PERSONAL INFORMATION: Date:____/___/____

Name:____ Gender: ___Male ___Female
Address:____
City/State/Zip:______________
Date of Birth:___/___/___ (Age:___) SSN:____/___/____
Primary Phone Number: ____-____-____
Cell Number: ____-____-_____
Email Address:_____________________@_________.com (all information is kept confidential)
Emergency Contact Name and Phone Number:____
Married__ Single___ Widowed___ Divorced___ Child___
***How did you hear about our office?**____

Patient Employment Information:

Current Employment: __Full time __ Part time __Retired __ Other
Name of Employer: ______________________________________Work Number:____________

Insurance Notification:
We **do not** file any primary insurance in this office other than Medicare
We **do not** file any secondary insurance in this office
We **do not** accept Medicaid
We **DO** supply patients with a walk out transaction report or other forms necessary so that you may file your insurance.
Full payment is expected up front on the date of your visit.

Medicare Notification: (If you are a Medicare patient you **Must** sign below)
I, the undersigned, understand that although the chiropractic services listed below may be necessary for the treatment of my condition, these services may **NOT** be covered by Medicare and I am financially responsible for all charges whether or not paid by Medicare. I authorize the office of Dr. Thomas P. McKay Jr. to release all information necessary to secure payment of benefits. I acknowledge this disclaimer with my signature here:___________________________

Non-covered Chiropractic Charges:
X-rays, Examination, Lab and Diagnostic Exams, Supports, Physical Therapy, Modalities and Nutritional Supplements.

What Is Covered by Medicare?

After you have met your deductible, Medicare will pay 80% of the allowable charge. Medicare covers manipulation of the spine if medically necessary to correct subluxation (when one or more of the bones in your spine move out of position) when provided by chiropractic physicians.

Chief Complaint: (reason why you are here today)
____
____
__

Past Surgeries/Hospitalizations:

Procedure:____ Date:______________________
Procedure:____ Date:______________________
Procedure:____ Date:______________________
Procedure:____ Date:______________________

Medical History:

Personal - Have you ever been diagnosed with any of the following?

__ asthma __pneumonia __tuberculosis __thyroid disease __kidney failure

__bronchitis __emphysema __hepatitis __high cholesterol __rheumatic fever

__diabetes __cancer __heart disease __blood disorder __blood clots

__high blood pressure __Other illness:___________________________________

Family - Check if any family history of the following:

__angina/heart attack __heart failure __high blood pressure __diabetes

__aneurysm __rheumatic fever __stroke __congenital heart disease

__high cholesterol __blood clots __bleeding disorders __kidney failure

__Other:____
_

Please rate your Overall Health:

__Excellent __Good __Fair ___Poor

Exercise:

__None __1-2 X week __3-4 X week __5 or more X week

List any type of exercise:____

Habits:

__Alcohol __Drinks per day __Street/Recreational Drugs __IV Drug use

__Smoking __Packs per day __Years of Smoking
__Testing for HIV or Hepatitis (please indicate result of testing)____________________________

Medications: (list all medications including over the counter medications that you are currently taking)

Name____ Strength_________
Dosage__________
Name____ Strength_________
Dosage__________
Name____ Strength_________
Dosage__________
Name____ Strength_________
Dosage__________
Name____ Strength_________
Dosage__________
Please list any allergies:
____
_

Diet History:

How much do you drink each day: __Coffee __Tea __Caffeinated Soda __Diet Soda

List oils you use for cooking:____
Circle the one that you use: Butter or Margarine
Do you know what partially hydrogenated fats are? __yes or __no
Do you eat them? __yes or __no

Do you frequently skip meals? __yes __no

Are you on any special diet or nutrition program? __yes __no
If yes, please explain:
____

Foods you are allergic to?
____

Foods you are sensitive to?
____

Foods you dislike? ____

Circle the foods that you crave:
Salty Sour Spicy Fatty-Foods Cereals Vegetables
Meats Fats Sweets Fruits Breads Dairy Other:__________________________________

What do you eat for breakfast? ____

What do you eat for lunch? ____

What do you eat for dinner? ____

What snacks do you eat between meals or before bed? __________________________________

What foods do you eat a lot of, at least once per day? ____________________________________

How many bowel movements do you have per day? _____________________________________

Symptom Survey:

Please check if you are experiencing any of these symptoms:

General: **__None** **Last Physical Date:**___________________________
__fever __anxiety __sweats __chills __weight gain
__weakness __fatigue __irritability __insomnia __depression

Skin: **__None**
__color changes __itching __easy bruising
__skin eruptions __scaling

Eyes: **__None** **Last Exam Date:**________________________________
__glasses/contacts __color blindness __sensitivity to light
__blurring __night blindness __double vision
__discharge __redness __excessive tearing

Ears: **__None**
__pain __ringing __itching __hearing aid __deafness
__dizziness __discharge

Nose: **__None**
__sinusitis __excessive bleeding __blockage __nasal discharge

Mouth: **__None** ****Last Dental Exam Date: ________________________**
__dentures __abnormal taste __speech difficulty
__hoarseness __gum disease __cavities

Neck: **__None**
__swelling __goiter __mass/nodules __pain __stiff neck

Respiratory: **__None**
__cough __bronchitis __asthma __sputum production
__wheezing __coughing up blood __shortness of breath
__frequent chest colds

Cardiovascular :**__None** ****Last Chest X-Ray Date:_________________________**
__chest pain __calf pain __enlarged heart __dizziness
__swelling __heart murmur __irregular/fast heart beat

Gastrointestinal: **__None**
__belching __constipation __tooth/gum disease __bloating
__diarrhea __mucous in stool __difficulty chewing __black stool
__vomiting __jaundice __difficulty swallowing __rectal pain
__heartburn __bloody stool __abdominal pain

Symptom Survey Continued:

Genitourinary: **__None**
__kidney stones __difficulty urinating __incontinence (leaking)
__blood in urine __painful urination
**How many times do you urinate during the night?_________________________

Endocrine: **__None**
__goiter __thyroid disorder __feel hot/cold when others do not

Neurological: **__None**
__seizures __frequent headaches __partial/temp loss of vision
__memory change __severe headaches
__partial/temp loss of speech __face numbness
__face tingling __weakness in arms or legs

Musculoskeletal: **__None**

__ joint swelling __bone/joint tenderness __backache

__ limitation of movement of joints

****Women Only Complete:****

__None

__vaginal discharge __breast discharge __hot flashes

__miscarriages __breast pump __abortions

__Birth Control: (list type)____

__IUD: (list year inserted) ____

Age menstruation began:______

Describe periods: __Regular or Irregular__

Date of last menstrual period: __/__/____

****Men Only Complete****

__None

__penis discharge __slow/weak urine stream __prostate trouble

__swelling or pain in testes

__vasectomy (date of surgery):____

Non Physical:

__None

__job problems __psychiatrist seen __depression

__relationship problems __personal problems

Other:____