McCartney Family Chiropractic and Wellness, P.C.
1079 S. Baldwin Rd., Orion Twp., MI 48360
(248) 391-1600

DATE: _____

PATIENT INFORMATION

Name: _____ ☐ M ☐ F Birthdate: ____/____/____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____-_____-_____ ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Spouse's Name: _____ Do you have children? ☐ Y ☐ N How Many? _____

Home #: _____ Cell #: _____ Email: _____

Preferred contact method: ☐ Home ☐ Work ☐ Cell Phone Carrier: _____

How did you hear about us? _____

EMERGENCY CONTACT

Name: _____ Relationship: _____Phone:_____

INSURANCE INFORMATION

Insurance Company: _____Contract/Enrollee _____ Group No._____

OCCUPATION

Employer Name: _____Employer Phone No. _____

Occupation: _____My job duties include: ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor

PATIENT COMPLAINTS (Please check all that apply)

Current	Past		Current	Past		Current	Past	
☐	☐	Neck pain	☐	☐	Mid back pain M54.6	☐	☐	Feet Numbness ☐L / ☐R
☐	☐	Neck Stiffness	☐	☐	Mid back stiffness	☐	☐	Constipation
☐	☐	Headaches	☐	☐	Shoulder pain ☐L / ☐R	☐	☐	Poor circulation
☐	☐	Dizziness	☐	☐	Shoulder tightness ☐L / ☐R	☐	☐	High blood pressure
☐	☐	Head feels heavy	☐	☐	Rib pain ☐L / ☐R	☐	☐	Asthma.
☐	☐	Twitching of face	☐	☐	Pain in side ☐L / ☐R	☐	☐	Loss of balance
☐	☐	Grating in neck	☐	☐	Chest Pain ☐L / ☐R	☐	☐	Loss of taste.
☐	☐	Muscle spasms in neck	☐	☐	Low back pain	☐	☐	Fatigue
☐	☐	Arm pain ☐L / ☐R	☐	☐	Low back stiffness	☐	☐	Nervousness.
☐	☐	Arm Numbness ☐L / ☐R	☐	☐	Hip pain ☐L / ☐R	☐	☐	Sleeping trouble
☐	☐	Wrist pain ☐L / ☐R	☐	☐	Leg pain ☐L / ☐R	☐	☐	Arthritis.
☐	☐	Hand Numbness ☐L / ☐R	☐	☐	Leg numbness ☐L / ☐R	☐	☐	Painful joints .
☐	☐	Cold Hands ☐L / ☐R	☐	☐	Knee pain ☐L / ☐R	☐	☐	Swollen joints.
☐	☐	Pain in ears ☐L / ☐R	☐	☐	Pain in feet ☐L / ☐R	☐	☐	Menstrual irregularity

HISTORY

Are your complaints related to an accident? ☐ yes ☐ no If yes, ☐ work related ☐ auto ☐ other _____

Does your pain interfere with your? ☐ Work ☐ Sleep ☐ Daily Routines ☐Recreation

Is it possible that you are pregnant? ☐ no ☐ yes

Have you ever had any injuries, accidents, or falls *(even if you think you were not hurt at the time)*? ☐ No ☐ Yes, if yes please indicate below.

When? Month_____ Year_____ Type of injury: _____

When? Month_____ Year_____ Type of injury: _____

When? Month_____ Year_____ Type of injury: _____

Please indicate what treatment/testing you have already received for these complaints

☐ Chiropractic ☐ Physical Therapy ☐ Medications ☐ Surgery ☐ MRI ☐ CT Scan ☐ None

☐ Other _____

Please indicate which doctors you have already seen for these complaints

Doctor: _____ Phone No. _____

Doctor: _____ Phone No. _____

Doctor: _____ Phone No. _____

SURGERIES

Surgery	Month/Year	Surgery	Month/Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Anemia	☐	☐	Anxiety
☐	☐	Bleeding disorders	☐	☐	Cancer	☐	☐	Chemical dependency
☐	☐	Depression	☐	☐	Diabetes	☐	☐	Epilepsy/Siezures
☐	☐	Fractures	☐	☐	Heart disease	☐	☐	Hepatitis
☐	☐	Hernia	☐	☐	Herniated disc	☐	☐	High cholesterol
☐	☐	Multiple sclerosis	☐	☐	Osteoporosis	☐	☐	Pacemaker
☐	☐	Parkinson's disease	☐	☐	Polio	☐	☐	Prostate problems
☐	☐	Prosthesis	☐	☐	Psychiatric care	☐	☐	Stroke
☐	☐	Suicide attempt	☐	☐	Thyroid problems	☐	☐	Tumors
☐	☐	Ulcers	☐	☐	Other _____			

MEDICATIONS, VITAMINS, AND SUPPLEMENTS

Medication	Dosage	Vitamin/Supplement	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES

Are you allergic to anything? ☐ No ☐ Yes (if "YES" please list any and all allergies)

_____
_____
_____

SOCIAL

My exercise level is: ☐ Intense ☐ Moderate ☐ Light ☐ Minimal ☐ None

My habits include: ☐ Smoking/Tobacco use _____packs/day ☐ Alcohol _____drinks/week

☐ Coffee _____cups/day ☐ Soda Pop _____cups/day ☐ Tea _____cups/day

☐ Recreational drug use ☐ Other _____

What goals would you like us to help you achieve? For example: pain management, increased movement, ability to lift, improved gait, ability to perform during sports, hobbies, or work, weight loss/diet/nutrition, etc….

FAMILY

Please mark the conditions that relate to your parents, siblings, or grandparents.

	Diabetes	Heart Disease	Cancer	Stroke	Thyroid	Arthritis	Mental Illness	Auto Immune	Back/ Spine	High Blood Pressure	Osteoporosis	High cholesterol
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother(s) # of: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister(s) # of: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother (maternal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather (maternal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother (fraternal)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

SUBJECTIVE FINDINGS *PAIN CLASSIFICATION*

CERVICAL:	☐ Mild	☐ Moderate	☐ Severe	☐ Sharp	☐ Dull	☐ Aching	☐ Intermittent	☐ Constant
THORACIC	☐ Mild	☐ Moderate	☐ Severe	☐ Sharp	☐ Dull	☐ Aching	☐ Intermittent	☐ Constant
LUMBAR:	☐ Mild	☐ Moderate	☐ Severe	☐ Sharp	☐ Dull	☐ Aching	☐ Intermittent	☐ Constant
PELVIC:	☐ Mild	☐ Moderate	☐ Severe	☐ Sharp	☐ Dull	☐ Aching	☐ Intermittent	☐ Constant

RANGE OF MOTION	**CERVICAL**				**LUMBAR**			
	+	**-**	**RESULT**	**NORM**	**+**	**-**	**RESULT**	**NORM**
Flexion				**45**				**90**
Extension				**45**				**30**
Lateral Flexion				**45R**				**30R**
Lateral Flexion				**45L**				**30L**
Rotation				**80R**				**30R**
Rotation				**80L**				**30L**

OBJECTIVE FINDINGS

CERVICAL: Muscle Spasms ☐ L ☐R ☐ Fixations _____

THORACIC: Muscle Spasms ☐ L ☐R ☐ Fixations _____

LUMBAR: Muscle Spasms ☐ L ☐R ☐ Fixations _____

PELVIS: Muscle Spasms ☐ L ☐R ☐ Fixations _____

AREAS OF TENDERNESS

CERVICAL: ☐ L ☐R _____
DORSAL: ☐ L ☐R _____
LUMBAR: ☐ L ☐R _____
PELVIC: ☐ L ☐R_ _____

POSTURAL DISTORTION

HEAD TILT: ☐L ☐R
Shoulder High On: ☐L☐R
Ilium High On: ☐L ☐ R
Forward Head Carriage: ☐ Y ☐ N

Absent **Hypoactive**
Normal **Hyperactive** **Hyperactive**

0	**1+**	**2+**	**4+**	**5+**	
					Biceps____L _____ R_____ C5, 6, Musculocutaneous N
					Brachioradialis____L _____ R_____ C6
					Triceps L _____ R _____ C6, 7 8, Radial N.
					Patellar L _____ R _____ L2, 3, 4, Femoral N.
					Achilles L _____ R _____ S1, 2, Tibial N.

ORTHOPEDIC TESTS

	L	R	N
Foraminal Compression	☐	☐	☐
Shoulder Depression	☐	☐	☐
Cervical Syndrome	☐	☐	☐
Supine Leg Check	☐	☐	☐
Soto-Hall	☐	☐	☐
Minor's Sign	☐	☐	☐
Bechterew's Test	☐	☐	☐
Kemp's	☐	☐	☐
Lindner's	☐	☐	☐
Braggard's	☐	☐	☐
Bilateral Leg lower/raise	☐	☐	☐
Heel and Toe Test	☐	☐	☐
Nachla's Test	☐	☐	☐
Ely's Test	☐	☐	☐
Hibbs	☐	☐	☐
Fabere-Patrick	☐	☐	☐
Gaenslen's Test	☐	☐	☐
Lasegue's _____ L _____R	☐	☐	☐
Apley's Scratch Test (shoulder)	☐	☐	☐
Apley's Aprehension (knee)	☐	☐	☐

At ☐	**1L** ☐		
Ax ☐	**2** ☐		
3 ☐	**3** ☐		
4 ☐	**4** ☐		
5 ☐	**5** ☐		
6 ☐			
7 ☐	**L. Ilium**		
1D ☐	**PI** ☐		
2 ☐	**As** ☐		
3 ☐	**In** ☐		
4 ☐	**Ex** ☐		
5 ☐			
6 ☐	**R. Ilium**		
7 ☐			
8 ☐	**PI** ☐		
9 ☐	**As** ☐		
10 ☐	**In** ☐		
11 ☐	**Ex** ☐		
12 ☐			

X-RAY REPORT & SPINAL ANALYSIS

Osteophytic Changes C ☐ T ☐ L ☐
Dengeneration C ☐ T ☐ L ☐
Loss of Lordotic Curve C ☐ L☐
Spina Bifida
Sacralization L ☐ R ☐
Lumbarization L ☐ R ☐
Neuroforaminal Stenosis C ☐ L ☐

Scoliosis (Lateral Curve)
Cervical ☐ L ☐ R
Thoracic ☐ L ☐ R
Lumbar ☐ L ☐ R

Spondylolisthesis Grade _____
Retrolisthesis Grade _____
Compression Fracture
Osteoporosis
☐ mild ☐ moderate ☐ severe

Spinal Fusion
☐ congenital ☐ surgical

Ht. _____ Wt _____ Blood Pressure _____ Ambulatory ☐ Yes ☐ No Antalgia ☐ Yes ☐ No

Special Instructions:

A	B	C	D
E	F	G	H
I	J	K	L

CORRECTIVE CARE PLAN

☐ Daily visits for _____ weeks
☐ 3 visits per week for _____ weeks
☐ 2 visits per week for _____ weeks
☐ 1 visit per week for _____ weeks
☐ 1 visit every 2 weeks ☐ 1 visit per month

☐ Spinal Manipulation
☐ Traction
☐ Ice ☐ Heat
☐ Spinal Decompression

☐ Laser
☐ Massage
☐ Exercises

M T W TH F SA SU

Doctor Signature **Date**