DOCTOR _____

DATE OF VISIT ___/___/20___ Patient_____ Age_____

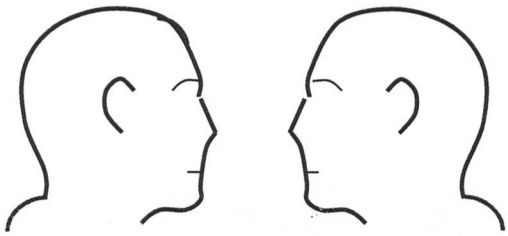
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms _____

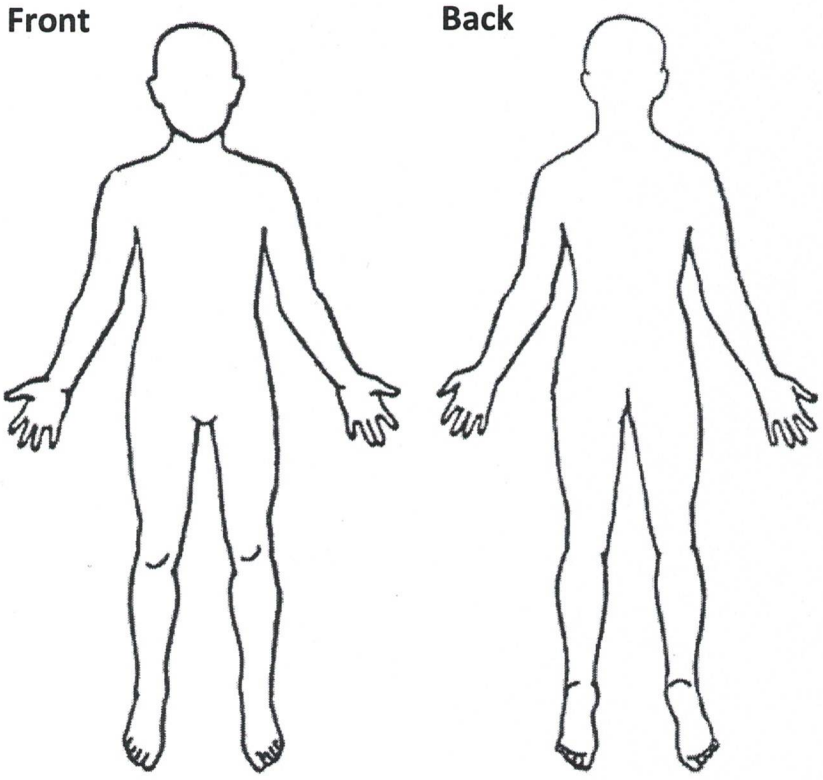
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? _____

SUBJECTIVE PAIN ASSESSMENT

Right **Left**



Front **Back**



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

_____ _____

Chiropractic Case History/Patient Information

Date:_____ Patient #_____ **Doctor:**_____

Name:_____ Social Security #_____Home Phone: _____

Address:_____City:_____ State:_____ Zip:_____

E-mail address:_____Fax #_____ Cell Phone:_____

Age:_____ Birth Date:_____ Race:_____ Marital: M S W D

Occupation:_____ Employer:_____

Employer's Address:_____ Office Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

How many children?_____Names and Ages of Children:_____

_____

Name of Nearest Relative:_____ Address:_____Phone:_____

How were you referred to our office?_____

Family Medical Doctor:_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?_____

Please check any and all insurance coverage that may be applicable in this case**:**

π Major Medical π Worker's Compensation π Medicaid π Medicare π Auto Accident
π Medical Savings Account & Flex Plans π Other

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

McFarland Spine & Sport

PATIENT NAME: _____ DATE: _____ DOCTOR: _____

HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto _____ Work _____ Other _____

Have you ever had the same or a similar condition? ( ) Yes ( ) No If yes, when and describe: _____

_____

Days lost from work: _____ Date of last physical examination: _____

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ( ) Yes ( ) No

If yes, describe: _____

_____

What medications or drugs are you taking? _____

_____

Do you have any allergies to any medications? ( ) Yes ( ) No
If yes, describe: _____

_____

Do you have any allergies for any kind? ( ) Yes ( ) No
If yes, describe: _____

_____

Do you have any Congenital Conditions? ( ) Yes ( ) No If yes, describe: _____
Women: Are you pregnant? _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

Headaches _____ Frequency _____	Loss of Balance _____	Cold Hands _____
Neck Pain _____	Fainting _____	Tension _____
Stiff Neck _____	Loss of Smell _____	Arthritis _____
Sleeping Problems _____	Loss of Taste _____	Irritability _____
Back Pain _____	Unusual Bowel Patterns _____	Chest Pain/Tight _____
Nervousness _____	Cold Fee _____	Muscle Spasms _____
Dizziness _____	Frequent Colds _____	Fever _____
Shoulder/Neck/Arm Pain _____	Numbness in Fingers _____	Sinus Problems _____
Numbness in Toes _____	High Blood Pressure _____	Diabetes _____
Indigestion Problems _____	Difficulty Urinating _____	Joint Pain/Swell. _____
Weakness in Extremities _____	Menstrual Difficulties _____	

McFarland Spine & Sport

PATIENT NAME: _____ DATE: _____ DOCTOR: _____

Breathing Problems	_____	Weight Loss/Gain	_____
Fatigue	_____	Depression	_____
Lights Bother Eyes	_____	Loss of Memory	_____
Ears Ring	_____	Buzzing in Ears	_____
Broken Bones/Fractures	_____	Circulation Problems	_____
Rheumatoid Arthritis	_____	Seizures/Epilepsy	_____
Excessive Bleeding	_____	Low Blood Pressure	_____
Osteoarthritis	_____	Osteoporosis	_____
Pacemaker	_____	Heart Disease	_____
Stroke	_____	Cancer	_____
Ruptures	_____	Coughing Blood	_____
Eating Disorders	_____	Alcoholism	_____
Drug Addiction	_____	HIV Positive	_____
Gall Bladder Problems	_____	Ulcers	_____

SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

OFTEN= "O" SOMETIMES= "S" NEVER "N"

_____Vigorous Exercise
_____Moderate Exercise
_____Alcohol Use
_____Drug Use
_____Caffeine
_____High Stress Activity

_____Family Pressures
_____Financial Pressures
_____Other Mental Stresses
_____Other (specify) _____
_____
_____

MCFARLAND SPINE & SPORT DR. MATTHEW MCFARLAND, D.C.

INFORMED CONSENT

PATIENT NAME: _____

Clinic Name: McFarland Spine & Sport

Doctor's Name: Matthew McFarland

Address: 290 N Kentucky Ave. West Plains, Missouri 65775

Phone: (417) 256-9172 Fax: (417) 204-5758

I will use my hands or a mechanical upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocation, Bernard-Horner's Syndrome, costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-ray. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

DATE: _____ _____

Printed Name

_____

Signature

_____

Signature of Parent or Guardian (if a minor)

What you can expect:

Thank you for choosing McFarland Spine and Sport for your care. The following information covers our basic policy and information on what you can expect, payments, and appointments.

At your initial appointment Dr. McFarland will do a detailed examination, during which he will personally meet with you to discuss all of your needs and concerns. During the time of your examination, you will both discuss and establish a treatment plan just for you. Your treatment plan is going to determine how often you need to seek treatment in order to stay healthy and feel your best. We strongly encourage you to keep on your treatment plan so that you always feel your best.

We believe in open communication between doctor and patient. Do not hesitate to discuss questions and feedback on your care process with the doctor at your scheduled appointments.

Payment Policy:

Payments are due at the time of service. We are happy to file all your charges to your insurance company if we are in network with them. However, we are not in network with all insurance companies. Anything that is not covered by your insurance (deductibles, co-insurance, co-pays, services not covered, etc.) you are responsible for.

Payment Types:

We take all major credit cards, debit cards, HSA cards, cash, or check. For a $2.00 convenience fee you can leave your card on file and we will run it for you after each visit. If you choose to pay with a card at the time of service, and physically hand us the card there will not be a $2.00 convenience fee. There is a $25.00 returned check fee if for some reason your check does not go through when we try to deposit it. **We cannot guarantee that your check will be deposited within the same week**

We do have forms for you to leave with your card information if you choose to take care of your bill that way.

Appointments:

We kindly ask that you give us 24-hour notice if you need to reschedule your or are unable to make your appointment for any reason. **If you do not give us a 24-hour notice or notice the day before you are subject to a $30 No call, no show (NCNS) fee.**

As of January 1, 2023, we do require confirmation of all appointments whether it is via text, email, or over the phone. You should receive a text the day before your appointment, at which time you can confirm. If you do not confirm via text or email the office will then call you to get confirmation.

Missing three or more consecutive appointments without any contact, makes you subjective to being released from care at our clinic.

Signature: _____ Date: _____