

JONATHAN WESLEY McCULLOUGH, D.C.

Board Certified in Rehabilitation

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I, _____, acknowledge that I have received from
_____ Jonathan W. McCullough, D.C. their "Notice of Privacy
Practices."

Patient's Name

Date

Witness

Date

Confidential Patient Information

Referred by whom? _____ SS#: _____
Name: _____ Age: _____ Birth date: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell #: _____
E-Mail Address: _____
Occupation: _____ Employer: _____ Marital Status: _____
Name of Nearest Relative: _____ Phone: _____
Name of Spouse: _____ # of Children: _____ Spouse's Occupation: _____
Spouse's Employer: _____ Date of Last Physical: _____
Briefly Describe Symptoms: _____
List All Other Doctors You Have Seen For This Condition: _____
Describe any Operations and incl. Respective Dates: _____
Serious Illness: _____

Insurance Data- Payment Arrangement Must Be Made On First Visit

Insurance Company Name: _____ Group #: _____ ID #: _____
Other Insurances (Incl. Spouse's Insurance Information)
Insurance Company Name: _____ Group #: _____ ID #: _____

I understand and agree that health and accident insurance policies between and insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY I constitute and hereby appoint Dr. Jonathan W. McCullough and any of his duly authorized agents and employees to be the undersigned's true and lawful attorney for and in the undersigned's name, place, and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and said doctor which checks, drafts or money orders are to pay for the services or the like which have been or are performed by doctor at request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order. However, I clearly understand/agree that all services rendered me will be due and immediately payable. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due/payable. I hereby authorize the doctor to treat my condition as he deems appropriate through the use of manipulation/therapy I hereby certify that I have read/fully understand the above Authorization for treatments, reason, advantage and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by the doctor. I also certify that no guarantee or assurance has been made as to the results that will be obtained. It is understood/agreed the amount paid to the doctor for x-rays, is for examination only and the x-ray negative will remain property of this office, ebbing on file where they may be seen at any time while a patient of this office. The medical center will not be held responsible for any pre-existing medical condition or for any medical diagnosis Patient is responsible for all co-pays and deductibles.

Patient Signature: _____ Date: _____
Guardian Signature Authorizing Care: _____ Date: _____

Medical History

Date: _____

Name: _____ Birthdate: _____ Sex: _____ Race: _____

Health History of Patient

	YES	NO
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Trouble or Stones	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Serious Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Other Illnesses	<input type="checkbox"/>	<input type="checkbox"/>

Explain all Yes Answers:

Surgical Procedures (include dates): _____

Current Medications and Dosage: _____

Allergies to Medicine:
(None)

Family History

	YES	NO
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Trouble or Stones	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Explain all YES answers:

Cause of death of parents, or brothers, or sisters:

Social History

Most Recent Occupation:

Married Single Divorced Widowed

Number of Children Living: _____

Number of Pregnancies: _____

Presently living alone:

Yes No

Smoke: _____ packs per day

Alcohol: Never Occasional Moderate to Heavy Drug Overuse: None Presently Past Problem

Review of Systems

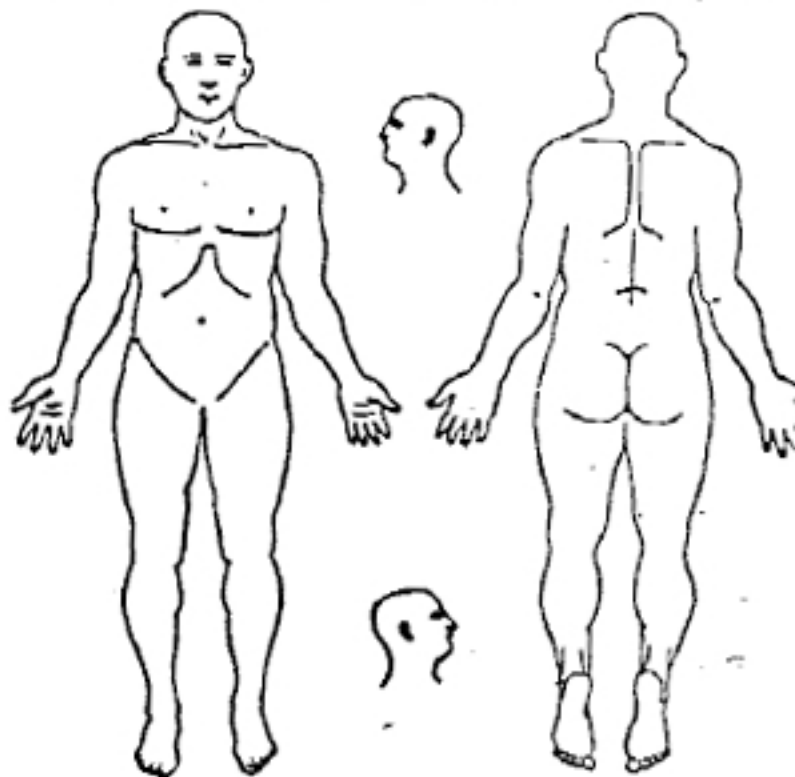
	YES	NO
Reading Glasses	<input type="checkbox"/>	<input type="checkbox"/>
Change of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Chills or Fever	<input type="checkbox"/>	<input type="checkbox"/>
Heart or Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Badly Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Calf Cramps with Walking	<input type="checkbox"/>	<input type="checkbox"/>
Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Pain	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Belching	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Loose Bowels	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Stools	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty:		
-Starting Urination	<input type="checkbox"/>	<input type="checkbox"/>
-Stopping Urination	<input type="checkbox"/>	<input type="checkbox"/>
Mid-night urination	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Rash	<input type="checkbox"/>	<input type="checkbox"/>
Hot or Cold Spells	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight change	<input type="checkbox"/>	<input type="checkbox"/>
Nervous Exhaustion	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
*Women Only:		
Irregular Period	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Spotting	<input type="checkbox"/>	<input type="checkbox"/>

CONSULTATION

Name: _____ Age: _____ Date: _____

Please Read Carefully: Mark the affected areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbols listed below. And using the space provided next to the diagram, PLEASE WRITE A DETAILED DESCRIPTION OF YOUR SYMPTOMS IN YOUR OWN WORDS.

Ache >>>>>
Burning XXXX
Numbness = = = = =
Stabbing / / / / /
Pins &
Needles o o o o o
Throbbing - ~ - ~ -



Please answer the following questions:

Where do you have pain? _____

When did you first begin to have pain? _____

Have you had this pain before? _____

Is your pain better or worse in the morning or night? _____

How often do you have pain? _____

What makes your pain worse? _____

What makes your pain better? _____

What other doctors have you seen for your pain? _____

Have any other doctors recommended surgery? Yes No

Are you taking medication for the pain? Yes No If so, what medications? _____

Do you smoke? _____ Time of last cigarette? _____

Do you have gout? _____ Diabetes? _____ Arthritis? _____

Have you had any fractures or surgery on your arms, legs, hands, or feet? _____

Patient's Signature _____

Please turn over and answer the questions on the back