McMullen Chiropractic Clinic* 3801 West Waco Dr. / Waco, Tx 76710

ENTRANCE RECORD: Please print or write legibly as we need all the facts about your health before we accept you as a patient. Your information will be kept confidential.

Name: ________________________ **Birth date:** _____ / _____/ ____ **Sex: M / F** **Date:**________________

Parent or Guardian – if patient is a minor; ______________________ **Relationship:**__________________

Address:________________________ **City:**__________________ **State:**________ **Zip:**____________

Phone Numbers: cell______________________ **home**______________________ **work**____________________

YOUR EMAIL:____

Occupation:______________________ **Retired / Unemployed *** Employer's name:**______________________

Job duties:____ **Number of months**______ **years:**______

Married / Single / Divorced / Widow * Spouse's name:**__________________________________

Previous Chiropractic: Yes / No * Where:**______________________________ **When:**____________

Family doctor:__________________________ **Which clinic/office?**______________________

EMERGENCY CONTACT: name__________________________ **phone number:**__________________

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Present complaint/symptom(s)____

____

____

When did your symptoms start? (**If filing insurance we must have a specific date**) ______________________

____

How did they start? UNKOWN ____

____

Have you seen anyone else for your symptoms? YES / NO *** If yes who and when:______________________

____

List any operations you have had and when: NONE / ____

____

____

List any broken / fractured bones: NONE / ____

Are you presently taking ANY PRESCRIPTION MEDICATION? YES / NO * What are you taking them for?

____

____

Do you have or have you had ? - **HIGH BLOOD PRESSURE** – yes no ** **DIABETES** - yes no ** **ANXIETY** - yes no **

CANCER – yes no **HEART ISSUES** - yes no ** **ARTHRITIS** - yes no ** **OSTEOPOROSIS** - yes no ** **DIZZINESS** - yes no

*************** **PLEASE TURN OVER AND COMPLETE THE BACK** ***************

MCMULLEN CHIROPRACTIC CLINIC

Patient:____ **Date:** ______________________________

PLEASE ANSWER THESE QUESTIONS BY CIRCLING YOUR RESPONSES

Do you currently have other health conditions? yes no - If yes what?____

Are you allergic to anything? yes no - if yes what ____

Are you a smoker? yes no ** If yes - cigarettes / e vape / cigars / dips / ______________________________________

Are you drinker? yes no ** If yes - beer / wine / hard liquor / ____

^^

On a scale of 0(none) to 10(severe) rate your symptoms.

0(none) 1 2 3 4 5 6 7 8 9 10(severe)

Are your symptoms (circle your answer)-

CONSTANT - **76% - 100% of the time you are awake - all day**

FREQUENT - **61% - 75% of the time you are awake - ¾ of the day**

INTERMITTENT - **26% - 50% of the time you are awake - half of the day**

OCCASIONAL - **1% - 25% of the time you are awake - ¼ of the day or less**

MARK ON THESE FIGURES WHERE YOUR SYMPTOMS ARE

RIGHT SIDE

BACK

LEFT RIGHT

FRONT

RIGHT LEFT

LEFT SIDE

SIGNATURE:____ **DATE:**___________________________