

# Sierra Vista Chiropractic, LLC

## PATIENT INFORMATION (please print)

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Nickname \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Ph: \_\_\_\_\_  
Cell Ph: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Age \_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_ Sex M F  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Office Ph: \_\_\_\_\_  
Married \_\_\_ S \_\_\_ W \_\_\_ D \_\_\_ Children \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Emergency Contact Name/Phone \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_  
Referred by \_\_\_\_\_ Yellow Pages \_\_\_ Newspaper \_\_\_ TV \_\_\_ Other \_\_\_

## RESPONSIBLE PARTY

Full Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Ph \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Employer \_\_\_\_\_ Business Ph \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## MEDICAL INSURANCE INFORMATION

Health Ins. \_\_\_ Worker's Comp. \_\_\_ Auto Liability \_\_\_ Medical Payments \_\_\_ Other \_\_\_  
Insurance Carrier \_\_\_\_\_ Id/Policy No. \_\_\_\_\_  
Group No. \_\_\_\_\_ Subscriber \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_  
Secondary Carrier \_\_\_\_\_  
Id/Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_  
Subscriber \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

### AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION, ASSIGNMENT OF BENEFITS

I authorize Sierra Vista Chiropractic, LLC to release medical information for insurance purposes concerning my treatment. I assign my rights to benefits to Sierra Vista Chiropractic, LLC and agree to pay any fees not covered by insurance. If my current policy mandates payment made to me then payment will be mailed to Sierra Vista Chiropractic, LLC. I authorize Sierra Vista Chiropractic, LLC to deposit payments made in my name for healthcare services received by me. If collection proceedings are required, I agree to pay collection fees. My signature authorizes Sierra Vista Chiropractic LLC to file a complaint with the insurance commission, when determined necessary, on my behalf.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself and that all services rendered me are charges directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Shaun P. McGuire, DC                      Jeannetta Young, DC  
222 E Fry Blvd  
Sierra Vista, Arizona 85635  
(520) 459-1414

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

HEALTH HISTORY INFORMATION (circle yes or no)

Is any other member of your family being treated in this office? \_\_\_\_\_

Have you ever had chiropractic care before? Yes No Were results satisfactory? Yes No

For what problem? \_\_\_\_\_

Major complaints and symptoms — please be as specific as you can. \_\_\_\_\_

How do you believe your problem (pain) began? \_\_\_\_\_

When did you first notice this problem/pain? \_\_\_\_\_

Have you lost any work? Yes No Day and date you last worked \_\_\_\_\_

Have you ever had this condition before or a similar condition? Yes No When? \_\_\_\_\_

What positions or activities aggravate your condition? \_\_\_\_\_

What positions or activities relieve your condition? \_\_\_\_\_

Have you ever been treated by a Medical Provider for this ailment? Yes No Who/where? \_\_\_\_\_  
Provider's Diagnosis \_\_\_\_\_

Describe the type of treatment \_\_\_\_\_

Length of time under care \_\_\_\_\_ Results \_\_\_\_\_

Have you ever been in any accidents i.e. auto, fall down stairs, fall from ladder, etc. (even as a child)?  
Yes No If yes, what and when? \_\_\_\_\_

Are you allergic to anything you are aware of? Yes No Substance? \_\_\_\_\_

Are you presently taking any medication, herbs, supplements or over the counter products (aspirin included)? Yes No If yes, name them \_\_\_\_\_

Have you ever broken any bones? (Fractures) \_\_\_\_\_ Any dislocations? \_\_\_\_\_

What operations have you had? 1) \_\_\_\_\_ Year \_\_\_\_\_ 2) \_\_\_\_\_ Year \_\_\_\_\_  
3) \_\_\_\_\_ Year \_\_\_\_\_ 4) \_\_\_\_\_ Year \_\_\_\_\_

Have you ever had any cosmetic surgery, breast implants, etc.? Yes No  
Body area? 1) \_\_\_\_\_ Year \_\_\_\_\_ 2) \_\_\_\_\_ Year \_\_\_\_\_

Have you had any surgery to replace hip, knee, etc.? Yes No  
Body area? 1) \_\_\_\_\_ Year \_\_\_\_\_ 2) \_\_\_\_\_ Year \_\_\_\_\_

If you have had any of the following procedures, please give date, treating doctor, and treating facility (if exact date is unknown, give approximate):

Blood tests \_\_\_\_\_ Urinalysis \_\_\_\_\_

X-Ray examination \_\_\_\_\_ Ultrasound \_\_\_\_\_

MRI \_\_\_\_\_ CT Scan \_\_\_\_\_

Radiation Treatment \_\_\_\_\_ Other special treatment \_\_\_\_\_

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

If yes, what condition? \_\_\_\_\_

Do you have any health problems not listed above? \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

Do you have any reason to believe that you may be pregnant? Yes No

Do you faint easily? Yes No Have you been diagnosed with hypertension? Yes No

Do you take vitamins? Yes No If yes, please list them \_\_\_\_\_

Do you exercise regularly? Yes No What kind of exercise? \_\_\_\_\_

Have you lost or gained weight in the past year? Yes No Amount \_\_\_\_\_

Habits: (please check)

Cigarettes? Yes No Packs \_\_\_\_\_per day Coffee? Yes No Cups \_\_\_\_\_per day

Alcohol? Yes No Drinks \_\_\_\_\_per day/week Tea? Yes No Cups \_\_\_\_\_per day

Hobbies? \_\_\_\_\_

Use this space for any additional information you may wish to discuss. \_\_\_\_\_

## REVIEW OF SYSTEMS

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter N if you have these conditions Now (within the past 12 months) or P if you ever had these conditions in the Past.

	N or P		N or P		N or P
Headaches	_____	Weakness in Legs	_____	Stomach Upset	_____
Neck Pain	_____	Shortness of Breath	_____	Constipation	_____
Stiff Neck	_____	Fatigue	_____	Cold Sweats	_____
Sleeping Problems	_____	Depression	_____	Fever	_____
Back Pain	_____	Lights Bother Eye	_____	Sinus Problems	_____
Nervousness	_____	Loss of Memory	_____	Diabetes	_____
Tension	_____	Ears Ring	_____	Hemorrhoids	_____
Irritability	_____	Face Flushed	_____	Leg Cramps	_____
Chest Pains	_____	Buzzing in Ears	_____	Colitis	_____
Dizziness	_____	Loss of Balance	_____	Gall Bladder	_____
Shoulder/Neck/Arm Pain	_____	Fainting	_____	Indigestion	_____
Pins & Needles in Arms	_____	Loss of Smell	_____	Belching	_____
Pins & Needles in Legs	_____	Loss of Taste	_____	Vomiting	_____
Numbness in Fingers	_____	Diarrhea	_____	Shoulder Pain	_____
Numbness in Toes	_____	Feet Cold	_____	Swelling Joints	_____
High Blood Pressure	_____	Hands Cold	_____	Knee Pain	_____
Difficulty Urinating	_____	Arthritis	_____	Hay Fever	_____
Allergies	_____	Muscle Spasms	_____	Menstrual Difficulties	_____
Weakness in Arms	_____	Frequent Colds	_____		

## ACCEPTANCE AS PATIENT

I understand and agree that the doctors of Sierra Vista Chiropractic, LLC have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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