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[www.McGunnigleChiropractic.com](http://www.McGunnigleChiropractic.com)

PATIENT INFORMATION & CONDITION FORM

PATIENT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_\_\_

ADRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY/STATE/ZIP CODE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell#\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-MAIL ADDRESS**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTH DATE \_\_/\_\_/\_\_\_\_ AGE: \_\_\_ SOCIAL SECURITY # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS (*Circle One*) Married Widowed Divorced Single

WHO MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTHCARE PROVIDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTHCARE PROVIDERS’S PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTHCARE PROVIDER’S ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YOUR OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER’S ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPOUSE’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPOUSE’S EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILDREN’S NAMES & AGES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT PHONE # & ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESCRIBE YOUR CONDITION, SYMPTOMS, OR THE PURPOSE OF THIS APPOINTMENT

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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HAVE YOU EVER HAD THE SAME OR SIMILAR CONDITION? YES\_\_\_ NO \_\_\_

IF YES, WHEN AND DESCRIBE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate previous Chiropractor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Visit Date \_\_/\_\_/\_\_\_\_

What type Chiropractic Technique was used\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT SURGERIES HAVE YOU HAD? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WHEN? \_\_/\_\_/\_\_\_\_

ANY SERIOUS ILLNESSES OR CONDITIONS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WHEN? \_\_/\_\_/\_\_\_\_

WHAT MEDICATIONS ARE YOU TAKING? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HAVE YOU EVER SUFFERED FROM: (*Circle all that apply*)

DIZZINESS ARTHRITIS DIGESTIVE DISORDERS

BACKACHES HEADACHES NERVOUSNESS

HEART TROUBLE NUMBNESS SINUS TROUBLE

DIABETES ASTHMA ANEMIA

HERNIA NEURITIS CANCER

OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WOMEN ONLY**: IS THERE A CHANCE YOU ARE PREGNANT? \_\_\_\_\_\_\_

Do you have Health Insurance? Yes \_\_ No \_\_ Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name of Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_/\_\_/\_\_\_\_

Does the policy Holder have the Insurance through his/her Employer? Yes \_\_ No \_\_

If yes, who is the Employer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself - NOT between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that my actual responsibility is neither a guarantee of payment by my insurance company , nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon the processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance company which may be responsible for paying benefits to me, and to any attorney who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collection from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_/\_\_/\_\_\_\_