CONFIDENTIAL PATIENT INFORMATION

IF YOU HAVE ALREADY FILLED OUT THE ONLINE REGISTRATION- GO TO PAGE TWO

The following information is needed in order to better serve you.
If you need help, please ask the receptionist.

Please Print and Fill Out Completely Date _____

Patient Name _____ Nickname _____
(Last) (First) (MI)

Address_____ City_____ State _____

Zip _____ Home Phone _____ Work # _____ Cell # _____

Birth Date _____ Sex at Birth: M F Marital Status: S M D W SSN (last four)_____

Spouse Name _____ # of Children _____ E-mail address: _____

Circle best method to contact you: phone: (Cell/text, home, work), mail, or e-mail or **all**:

Persons & relationship authorized to access your records _____

Name & phone of nearest relative (not spouse): _____

Your Age _____ Student? Yes No Name of Parent or Guardian if a Minor _____

Occupation _____ Patient Employer _____

Employer Address _____ City _____ State _____ Zip _____

Mobile or Alternate Phone _____ Full time or Part time Employment

What brings you in today/ Major Complaint _____

_____

If an Injury, due to Accident? Auto Work Home Other _____ Date of Injury/Illness _____

Similar Symptoms? Y N When? _____

Other accidents in: (circle one) Past 12 months 1-5 yrs. 5 yrs. or over Describe accident _____

_____

Previous Chiropractic Care? Y N Dr. Name, Location, Dates? _____

Similar or different condition _____

How did you find our office? Ad ____ Phone Book ____ Office Sign ___ Webpage _____ Other _____

Friend/Relative Name _____ Dr or staff contact _____

Health History

Name _____**Date** _____

List All Current Health Problems or Other Conditions: _____

_____

List Any Other Doctors Seen, Treatments and Results Obtained: (use back if needed)_____

_____

Your Current Physician(s) Therapist(s): _____

_____

List All Surgeries and Their Dates: _____

_____

List Any Medications You Are Taking:_____

_____

List Any physical injuries and Their Dates: _____

_____

List Any Allergies you have: _____

_____

Please Check The Conditions You Have or Have Had:

( ) AIDS
( ) Anemia
( ) Arthritis
( ) Cancer
( ) Chronic fatigue
( ) Depression
( ) Dysautonomia
( ) Diabetes
( ) Epilepsy
( ) Fibromyalgia
( ) Low Blood Sugar
( ) Multiple sclerosis
( ) Parkinson's disease
( ) Polio
( ) Rheumatic fever
( ) Rheumatoid arthritis
( ) Tuberculosis
( ) STI/VD/STD disease
( ) Covid-19/Corona virus

Please Check All Present Symptoms:

CARDIOVASCULAR
( ) General swelling
( ) Swelling in legs
( ) Swelling in face
( ) Swelling around eyes
( ) Chest pain
( ) Pounding heart beat
( ) Rapid heartbeat
( ) Irregular heartbeat
( ) Blue or purple skin
( ) Blue or purple nail bed
( ) Cold hands/feet

VERTEBROBASILAR (Neck and Back of head)
( ) Double vision
( ) Loss of coordination
( ) Loss of memory
( ) Ringing in ear _both R L
( ) Heart attack
( ) Hardening of Arteries
( ) Muscle weakness
( ) Vertigo
( ) Blurred vision
( ) Stroke
( ) Hypertension/HBP
( ) Inability to form words
( ) Burning sensations
( ) Blindness
( ) Previous head injury
( ) Previous neck injury
( ) Taking birth control pills
( ) Family history of stroke
( ) Low Blood pressure
( ) Check if you smoke
( ) Fainting/near fainting
( ) Area of numbness

Musculoskeletal System

Name _____**Date**_____

Please Check All Present Symptoms:

Head
( ) Frequent headaches
( ) Severe headaches
( ) Head feels heavy
( ) Vertigo (spinning, loss of balance)
( ) Sharp/sudden pain in head/stabbing
( ) Light headedness
( ) Loss of taste
( ) Loss of smell
( ) Loss of hearing
( ) Loss of balance w/o spinning

Neck
( ) Pain in neck
( ) Pain with movement
( ) Swelling in neck
( ) Stiffness in neck
( ) Pinched nerve in neck
( ) Neck feels out of place
( ) Muscle spasms in neck
( ) Grinding sounds in neck
( ) Popping sounds in neck

Mid-back
( ) Mid-back pain
( ) Pain between shoulder blades
( ) Sharp stabbing pain
( ) Dull ache
( ) Pain over kidney area
( ) Muscle spasms

Lower Back
( ) Lower back pain
( ) Lower back feels out of place
( ) Muscle spams
( ) Limited motion

Shoulders
( ) Pain in shoulders
( ) Pain across shoulders
( ) Muscle spasms
Can't raise arm
( ) Above shoulder
( ) Above head

Arms & Hands
( ) Pain in upper arm
( ) Pain in forearm
( ) Pain in hands
( ) Pain in fingers
Pins & Needles
( ) In arms
( ) In fingers
( ) Hands/Fingers go to sleep
( ) Cold hands
( ) Swollen fingers
( ) Loss of grip strength

Hips, Legs & Feet
( ) Pain in buttocks (not including friends/family)
( ) Pain in hip
( ) Pain down leg __ both __R __L
( ) Knee pain __ both __R __L
( ) Leg cramps
( ) Pins & needles in legs
( ) Numbness in feet or toes
( ) Cold feet
( ) Swollen ankles
( ) Swollen feet

Doctor's Notes:

Systems Review

Name _____**Date** _____

Please Check All Present Symptoms:

Skin, Hair, Nails
( ) Eczema
( ) Itchy skin
( ) Rough, scaly skin
( ) Dry skin
( ) Oily skin
( ) Yellow skin
( ) Bruise easily
( ) Baldness
( ) Paper thin nails
( ) Nail biting
( ) Nail abnormalities (spots, splits, etc)

Eyes
( ) Blurred vision
( ) Double vision
( ) Eye fatigue
( ) Excessive tearing
( ) Lack of tearing/dry eyes
( ) Light bothers eyes
( ) Excessive itching
( ) Pain in eyeball

Ears
( ) Loss of hearing
( ) Sounds muffled
( ) Pain in ears
( ) Discharge from ears
( ) Vertigo
( ) Ringing in ears

Nose & Sinuses
( ) Nose bleeds
( ) Pressure over eyes
( ) Nose obstruction
( ) Frequent colds
( ) Sinusitis
( ) Loss of smell
( ) Allergies

Mouth & Throat
( ) Pain in Throat
( ) Bleeding gums
( ) Abscessed teeth
( ) Dentures
( ) Difficulty swallowing
( ) Tongue swells, patches

Respiratory
( ) Shortness of Breath
( ) Dry cough
( ) Coughing
( ) Wheezing
( ) Productive cough

Gastrointestinal
( ) Poor appetite
( ) Constant nibbling
( ) Difficulty swallowing
( ) Indigestion
( ) Nausea & vomiting
( ) Abdominal pain
( ) Change in bowel habits
( ) Diarrhea
( ) Constipation
( ) Hemorrhoids

Genitourinary
Urination is
( ) Frequent
( ) Not often enough
The amount is
( ) High
( ) Moderate
( ) Low
( ) Frequent urination at night
( ) Urgency to urinate
( ) Difficulty urinating
( ) Lack of control
( ) Painful urination
( ) Dribbling
( ) Bloody urine
( ) Cloudy urine
( ) Persistent bubbles in urine

STI/VD/STD
( ) Syphilis
( ) Gonorrhea
( ) Other _____

Hypersensitivities
( ) Taste ( ) Touch/ skin
( ) Smell ( ) Noise
( ) Visual- light/motion/patterns

Women Only
( ) Painful periods
( ) Spotting
( ) Premenstrual symptoms
( ) Irregular periods
( ) Lumps in breast
( ) Vaginal discharge
( ) # of pregnancies _____
( ) # of deliveries _____

Social History
( ) Smoking
( ) Other tobacco use
( ) Alcohol use
( ) Drink coffee or tea
Diet is
( ) Balanced
( ) Not balanced
Rest is
( ) Sufficient
( ) Not sufficient
Recreation is
( ) Sufficient
( ) Not Sufficient
Family stress is
( ) Severe
( ) High
( ) Moderate
( ) Minimal
( ) None
Job Stress is
( ) Severe
( ) Moderate
( ) Minimal
( ) None

( ) Nervousness
( ) Irritability
( ) Fatigue
( ) Depression
( ) Panic Attacks
( ) Problems sleeping
( ) Generally feel run-down

HIPAA Policy Required Authorizations

Patient Name: _____ Date of Birth: _____ M or F

Patient's Mailing Address: _____ City _____ St./zip _____

Social Security Number: _____

I authorize the release, disclosure and use of health information obtained on the above individual for the purpose of continuing care and treatment by:

Lonny McKinzie, D.C.
601 Chase Dr., Ste. A
Tyler, TX 75701
Phone: 903-531-2243

This information is to include: (Doctor will check information needed)

___ most recent date of treatment,
___ most recent discharge summary or for dates _____,
___ most recent history and physical or dates _____,
___ most recent Operative Report or dates _____,
___ lab results,
___ pathology reports,
___ radiology and imaging reports or dates _____,
___ other tests (specify)_____,
___ Entire Medical Records for dates _____,
___ pictures.

I understand that the information used or disclosed pursuant to this authorization form may include information relating to HIV or AIDS; treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand the authorization is valid indefinitely unless otherwise stated. I understand that I may revoke this authorization at any time and that if I revoke this authorization, I must do so in writing to Dr. McKinzie at the above address. I understand that the revocation will not apply to information that has already been released in response to this authorization.

<u>You have the right to withdraw authorization in writing at any time.</u>

I have read and understand the above stated authorizations and agree to those that have been checked.

X _____ _____
Signature of Patient or Qualified Personal Representative — Printed Name

_____
Authority to act on behalf of patient (Parent/Guardian, executor, etc.)

_____ _____
Signature of Witness — Printed Name of Witness

_____ Rev. 020121
Date

Permission to Contact Authorization

HIPAA Policy Required Authorizations

PLEASE INITIAL EACH ONE YOU GIVE US PERMISSION TO USE:

____ I give my permission for Lonny R. McKinzie, D.C. and staff to send me via mail or e-mail the following:

A. Birthday or Christmas cards, Thank you cards, or notices of special events or a Patient Appreciation Day. These cards may contain offers for discounted service or products.
B. Patient's newsletters about our office, upcoming products and services or general information.

____ We may use your name in office waiting area, web, email or in printed material to acknowledge your birthday, success in treatment, winner of contest or other office promotions.

____ We have your permission to use your child's (first) name, picture or drawing in our office or in printed material.

Address to use for mail (if different from above): _____

Circle the method of contact you prefer: mail phone email text _____ (number)

Email address: _____

This is to inform you that we also may call you to remind you of appointments or to follow-up with you after treatment.

We will attempt to send reminders of appointments, missed appointments, or the need for additional information through your designated preference above.

If you wish to change the address or phone number where you can be reached, you may do so in writing, by calling the office or request an update form from the office.

Please be aware that we have an open office adjusting setting. If you have a private matter you need to discuss regarding payment or treatment, please inform the front desk or the doctor in order to make arrangements for a more secure area to discuss private matters. For your protection, our employees or business associates must sign a confidentiality agreement regarding our office procedures and the use of your private health information. Staff only has rights to your information needed to perform their job duties. An example of a business associate can be anyone who we contract out to do transcriptions, record copying, a management company, or collection agencies. We have implemented agreements, policies and procedure to assure the protection of your privacy.

IMPORTANT: If you wish to allow a spouse or family member access to health information you must sign to give permission. Only those listed below will have access to your records.

"I give the following person or person's permission to access my health information: (Please check or list)

____ Any family member or spouse

OR (Only those listed below have access to your records)

_____

I have read and understand the above stated authorizations and agree to those that I have initialed.

X _____ _____
Signature Printed Name

_____
Date

Rev. 020121

Lonny R. McKinzie, D.C.

601 Chase Dr., Ste. A
Tyler, TX 75701

903-531-2243
www.DrMcKinzie.com