MAGOS CHIROPRACTIC PATIENT INTRODUCTION CARD

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU, PLEASE COMPLETE ALL QUESTIONS DATE:

1. Name	**2. Phone (Home):**	**Cell:**	
3. Complete Address (include city, state and zip)		**4. Date of Birth**	**5. Age**
6. ☐ Married ☐ Widowed ☐ Male ☐ Single ☐ Divorced ☐ Female	**7. No. of Children and their ages**	**8. Occupation**	
9. Employer name, address and phone no.			
10. Referred by	**11. E-mail Address (optional)**		

12. Have you had Chiropractic care before? ☐ Yes w/ whom? _____ Where?_____ ☐ No

What condition? _____ How Long Ago? _____

13. Do you have health insurance? (If yes, please give the receptionist your ins. card. for verification)
☐ Yes ☐ No Name of Insurance: Do you have a Flex Pay Account? ☐ Yes ☐ No

14. Where do you feel the problem? What is your major complaint?

15. Please indicate if you are here for care because of: ☐ an on the job injury ☐ an auto accident ☐ home injury

Date injured	Insurance Company	Attorney's name (if any)	Attorney's address

16. Have you ever had any falls, auto accidents, or injuries? ☐ Yes Please describe ☐ No	**Month, Year**	**Type of Accident**	**Describe Injury**

17. Have you ever had surgery? ☐ Yes Please explain ☐ No	**Month, Year**	**Type of Surgery**	**Comments**

18. Are you presently taking any medications? ☐ Yes Please list ☐ No	**Name of Drug**	**Doses per Day**	**Length of Time Taking**

Does your treatment with this office involve an attorney? _____ Yes _____ No
If so, please fill in No.15 above.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Mark Magos 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 Dr. Mark Magos will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged 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.

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19. Please check all of the following symptoms and signs that you now have or have had within the last 6 months. An understanding of your health status will facilitate care.

A. Musculo-skeletal

- ❑ Weakness
- ❑ Twitching
- ❑ Stiff neck
- ❑ Neck pain
- ❑ Muscle spasm in neck
- ❑ Grating or grinding in neck
- ❑ Pain in shoulders and arms
- ❑ Tightening of shoulder muscles
- ❑ Pins and needles in arms and hands
- ❑ Cold hands
- ❑ Backache
- ❑ Swollen joints
- ❑ Painful joints
- ❑ Pins and needles in legs
- ❑ Tremors
- ❑ Foot trouble
- ❑ Cold feet
- ❑ Painful tail bone
- ❑ Hernia
- ❑ Spinal curvature
- ❑ Faulty posture

B. General Symptoms

- ❑ Headache
- ❑ Fever
- ❑ Chills
- ❑ Night Sweats
- ❑ Fainting
- ❑ Dizziness
- ❑ Convulsions
- ❑ Loss of Sleep
- ❑ Fatigue
- ❑ Nervousness
- ❑ Allergy
- ❑ Wheezing
- ❑ Neuralgia
- ❑ Diabetes
- ❑ Cancer
- ❑ Arthritis
- ❑ Crying spells
- ❑ Frequent anger
- ❑ Fear

C. Gastro-Intestinal

- ❑ Poor appetite
- ❑ Poor digestion
- ❑ Excessive hunger
- ❑ Belching or gas
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Pain over stomach
- ❑ Constipation
- ❑ Diarrhea
- ❑ Colon Trouble
- ❑ Hemorrhoids (piles)
- ❑ Liver Trouble
- ❑ Jaundice
- ❑ Gall bladder trouble
- ❑ Stomach trouble

D. Cardio-Vascular

- ❑ Rapid heart beat
- ❑ Slow heart beat
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pain over heart
- ❑ Previous heart trouble
- ❑ Swelling of ankles
- ❑ Poor circulation
- ❑ Varicose Veins
- ❑ Strokes

E. Eye, Ear, Nose, Throat

- ❑ Poor vision
- ❑ Crossed eyes
- ❑ Pain in eyes
- ❑ Deafness
- ❑ Earache
- ❑ Ear noises
- ❑ Ear discharge
- ❑ Nasal obstruction
- ❑ Nose bleeds
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Hay Fever
- ❑ Asthma
- ❑ Frequent Colds
- ❑ Tonsillitis
- ❑ Sinus Trouble
- ❑ Thyroid Trouble

F. Skin

- ❑ Skin eruptions
- ❑ Itching
- ❑ Bruising
- ❑ Dryness
- ❑ Boils
- ❑ Sensitive skin
- ❑ Hives or allergy
- ❑ Eczema
- ❑ Psoriasis

G. Respiratory

- ❑ Chronic cough
- ❑ Spitting blood
- ❑ Spitting phlegm
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Lung problems

H. Genito-Urinary

- ❑ Frequent urination
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Kidney infection
- ❑ Bladder infection
- ❑ Bed wetting
- ❑ Inability to control urine
- ❑ Prostate trouble

I. For women only

- ❑ Painful periods
- ❑ Excessive flow
- ❑ Irregular cycles
- ❑ Hot flashes
- ❑ Cramps or backaches
- ❑ Miscarriage
- ❑ Vaginal discharge
- ❑ Pregnant at this time

STATEMENT TO CURE: Chiropractic makes no claim to cure the above conditions or any others, but only to adjust subluxation (misalignments of the spine) thus restoring better nerve supply for restoration of health.

MAGOS CHIROPRACTIC
Taking Care of Patients Since 1985
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