Dr. Thomas A. Maguire
2825 E 4th Avenue
Hialeah, Florida. 33013 305-693-0033

PATIENT INTAKE FORM

Name: _____ Today's Date_____

Address:_____

City: _____ State: _____ Zip Code: _____

Telephone (Cell): _____ (Work): _____

(Home): _____ (Email): _____

Date of Birth: _____ Age: _____ Gender: ____ M ____ F # of Children_____

Marital Status: _____M ____ D ____ S ____ W Spouse's Name_____

Occupation: _____ Employer: _____

Primary Health Care Provider: (Name/Number/Address) _____

List medications or vitamins you are presently taking (or please provide a copy of the list)

_____

Emergency Contact: _____ Phone: _____

Insurance Carrier _____ Policy # _____

Have you had a Chiropractic Care before? ____Yes ____No When: _____

With whom: _____

Have you seen any other doctor for this condition? ____Yes ____No

If yes please indicate whom and your results?

_____

Have you ever had surgery? ____Yes ____ No Please list what type of surgery and date:

_____

Do you have a pacemaker? ____Yes ____ No

FEMALES ONLY:

If Female are you pregnant? ____Yes ____No If so, give date of your last menstruation _____

Due Date: _____Are you taking birth control medication: ____ Yes ___ No

Social History/Habits:

Do you drink alcohol? _____ Yes _____ No If so how much a day? _____

Do you smoke? _____ Yes _____ No If so how much a day? _____

Do you use Tobacco? ____ Yes _____ No If so how much a day? _____

Do you participate in any athletic activities? ___ Yes ___ No Which one(s)? _____

Dr. Thomas A. Maguire
2825 E 4th Avenue
Hialeah, Florida. 33013 305-693-0033

Please circle the appropriate answer if you are experiencing or have experienced any of the following conditions:

	Circle all that apply							
	Current	Past		Current	Past		Ciurrent	Past
Low Back Pain:	X	X	Dizziness:	X	X	Hearing Loss:	X	X
Pain or Spasm in Neck:	X	X	Fatigue / Fainting:	X	X	Ringing in Ear:	X	X
Thyroid Trouble:	X	X	Bladder Problem:	X	X	Rheumatic Fever:	X	X
Numbness in Legs:	X	X	Diabetes:	X	X	Psoriasis:	X	X
Poor Circulation:	X	X	Cold Feet:	X	X	Menstrual Irreg:	X	X
Pins and Needles:	X	X	Heart Condition:	X	X	Menstrual Cramps:	X	X
Anxiety / Depression:	X	X	Shortness of Breath:	X	X	Shingles:	X	X
Pain in Legs or Feet:	X	X	HIV:	X	X	Fracture:	X	X
Swollen Joints:	X	X	Chest Pain:	X	X	Ringing in ears:	X	X
Arthritis / Bursitis:	X	X	Blood Clots:	X	X	Migraine:	X	X
Osteoporosis:	X	X	Low Blood Pressure:	X	X	Kidney Stones:	X	X
Knee Pain:	X	X	High Blood Pressure:	X	X	Tendonitis / Bursitis:	X	X
Hip Disorders:	X	X	Asthma / Emphysema:	X	X	Headache:	X	X
Foot or Ankle Pain:	X	X	Cancer:	X	X	Ulcer:	X	X
Shoulder Problems:	X	X	Anemia:	X	X	Scoliosis:	X	X
Elbow / Wrist pain:	X	X	Indigestion:	X	X	Tension /Stress:	X	X
Constipation:	X	X	Numbness in Arms:	X	X	Gall Bladder Pains:	X	X
Herniated disc:	X	X						

Other problems not listed above_____

_____

Please answer the following questions regarding your symptoms:

1. When did the problem begin_____ **Have you had this problem in the past? ___ Yes ___ No**

2. How often is the pain present? ____ Constant (80-100%) ____ Frequent (50-80%)
____ Occasional (25-50%) ____ Intermittent (less than 50%)

3. Since the problem began, the pain is? ____ Getting better ____ Getting worse ____ Same

4. How did your problem begin?
____ Auto Accident ____ Work related accident ____ Other type of accident
____Gradual onset ____ Sudden Onset ____ No specific reason

5. What makes the problem better?

____ Nothing ____ Walking ____ Sitting ____ Movement ____ Lying down ____ Inactivity

6. What makes the problem worse?
____ Nothing ____ Walking ____ Sitting ____ Movement ____ Lying down ____ Inactivity

7. Does the pain wake you up out of sleep without movement? ____ Yes ____ No ____ Sometimes

Dr. Thomas A. Maguire
2825 E 4th Avenue
Hialeah, Florida. 33013 305-693-0033

8. How would you describe your pain? ____ Sharp ____ Soreness ____ Throbbing ____ Tingling ____ Dull ____ Stiffness ____ Spasms ____ Burning ____ Ache ____ Weakness ____ Numbness ____ Shooting

9. Is your pain more in the morning or in the evening? ____ AM ____ PM ____ Same Always

10. Does your pain radiate?
___ Radiate from your back to above your knees ____ Radiate below the knee ____ Back and Hip ____ Neck Only ____ Radiate to arm above the elbow ____ Radiate below elbow ____ N/A

11. Has your appetite diminished since this pain began? ____ Yes ____ No

12. Is the problem affecting your ability to do work or other daily activities? _____ No effect
_____ Have some limited physical restriction's, but can function ____ Totally disabled
_____ Need some assistance with daily activity____ Cannot function without assistance
____ Cannot work

13. Since your pain began have you experienced?
____ Fever ____ Night Sweats ____ Chills ____ Unexplained weight loss ____ None

14. How long before you had this pain did you first seek treatment?
____ 1 week or less ____ 1-6 wks ____ More than 6wks – less than 3mth
____ 3mths to 1yr ____ Over 1yr.

15. How many times have you had this problem in the past?
____ Never ____ 1-3 episodes ____ 4 or more episodes

Please indicate if there is any one in your immediate family with a history of any of the following:
Cancer: ____ Yes ____ No Whom: _____
Heart Disease: _____Yes ____ No Whom:_____
Diabetes: ____ Yes ____ No Whom: _____

From 1-10 Please rate your pain level: (0 being no pain and 10 being maximum pain)
At Best

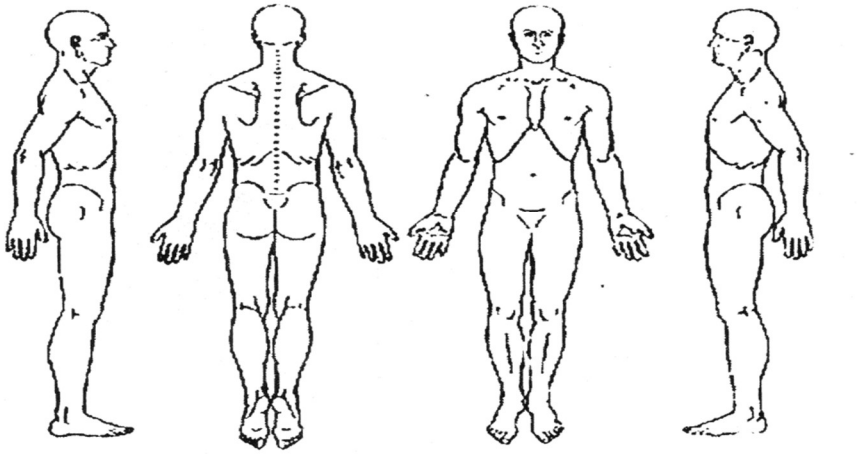
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

At worse

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Dr. Thomas A. Maguire
2825 E 4th Avenue
Hialeah, Florida. 33013 305-693-0033

Please Indicate (X) on the Diagram Where your pain is located:



Acknowledgements

I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in this office.

I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor, please print the child's full name: _____

Patients Name Printed: _____

Signature: _____ Date: _____