CONFIDENTIAL
HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

May Family Chiropractic
Dr. Eric R. May
506 Taylor Avenue
Annapolis, MD 21401
(410) 263-5051
www.mayfamilychiro.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
○ No ○ Yes **When?**

Whom may we thank for referring you?

If So, whom?

Your Last Name

Gender
○ Male ○ Female

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status
○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?
○ Yes ○ No

Address

Preferred method of contact?
○ Home Phone ○ Cell Phone ○ Work Phone

City

State/Province

ZIP/Postal Code

Work Phone

Insurance Carrier

Policy Number

Primary Care Provider's Name

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?
○ Self ○ Spouse ○ Parent

First Name

Middle name (or Initial)

Insured's Employer

Address

City

State/Province

Zip/Postal Code

Employer's Phone

Patient name _____

1. The symptom(s) that have prompted me to seek care today include: _____

2. And are the results of (darken circle):

- ○ An accident or injury
- ○ Work ○ Auto ○ Other _____
- ○ A worsening long-term problem
- ○ An interest in: ○ Wellness ○ Other _____

3. Onset (When did you first notice Your current symptoms?)

_____

4. Intensity (How extreme are your Current symptoms?)

0 ○—○—○—○—○—○—○—○—○—○ **10**

Absent Uncomfortable Agonizing

5. Duration & Timing (When did it start & how often do you feel it?

- ○ Constant
- ○ Comes & goes. How Often?

6. Quality of symptoms (What does it feel like?)

- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramps
- ○ Nagging
- ○ Sharp
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ Other:

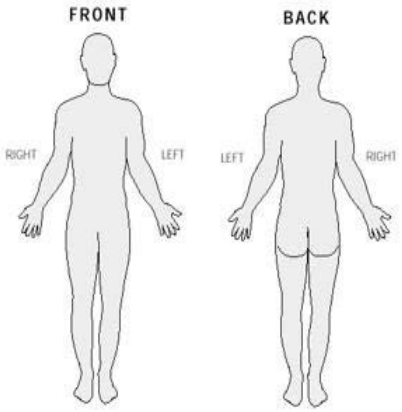
_____

_____

7. Location (How extreme are your current symptoms?)

Circle the area(s) on the illustration.

"O" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

_____

_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem?

_____

What tends to lessen the problem?

_____

10. Prior interventions (What have you done to relieve the symptoms?)

- ○ Prescription Medication ○ Surgery ○ Ice
- ○ Over the counter drugs ○ Acupuncture
- ○ Homeopathic remedies ○ Chiropractic ○ Heat
- ○ Physical therapy ○ Massage
- ○ Other: _____

11. What else should Dr. May know about your current condition? _____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

Consultation Notes

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which control & regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right. If none of the conditions in a line apply please place your initials on the line below the word None.

a. Musculoskeletal

Had Have		Had Have		Had Have		Had Have		Had Have		Had Have		None
○ ○	Osteoporosis	○ ○	Arthritis	○ ○	Scoliosis	○ ○	Neck pain	○ ○	Back problems	○ ○	Hip disorders	____
○ ○	Knee injuries	○ ○	Foot/ankle pain	○ ○	Shoulder problems	○ ○	Elbow/wrist pain	○ ○	TMJ Issues	○ ○	Poor posture	____

b. Neurological

Had Have		Had Have		Had Have		Had Have		Had Have		Had Have		None
○ ○	Anxiety	○ ○	Depression	○ ○	Headache	○ ○	Dizziness	○○	Pins & needles	○ ○	Numbness	___

c. Cardiovascular

Had Have		Had Have		Had Have		Had Have		Had Have		Had Have		None
○ ○	High blood pressure	○ ○	Low blood pressure	○ ○	High cholesterol	○ ○	Poor circulation	○ ○	Angina	○ ○	Excessive bruising	____

d. Respiratory

Had Have		Had Have		Had Have		Had Have		Had Have		Had Have		None
○ ○	Asthma	○ ○	Apnea	○ ○	Emphysema	○ ○	Hay fever	○ ○	Shortness of breath	○ ○	Pneumonia	___

e. Digestive

Had Have		Had Have		Had Have		Had Have		Had Have		Had Have		None
○ ○	Anorexia or bulimia	○ ○	Ulcer	○ ○	Food sensitivities	○ ○	Heartburn	○ ○	Constipation	○ ○	Diarrhea	___

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Patient name

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste	___

g. Integumentary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair Loss	○	○	Rash	___

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypo-glycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy	___

i .Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms	___

j .Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		None
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss	○	○	Weakness	___

Past Personal, Family & Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please completse each section fully.

Personal

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Rheumatic fever
○	○	Cancer	○	○	Scarlet fever
○	○	Chicken pox	○	○	STD
○	○	Diabetes	○	○	Stroke
○	○	Epilepsy	Other: _____		
○	○	Glaucoma	_____		
○	○	Goiter			
	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			

15. Operations

Surgical interventions, which may or may not have included hospitalisation.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- Other: _____
- _____
- _____

16 Treatments

Check the ones you've received in the **Past** or **Currently.**

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic Care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

Consultation Notes

17. Injuries

Have you ever…

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tottoo
- ○ Had a body piercing

List: _____

_____

○ ○ Medications Rx & OTC

18. Family History

Some health issues are hereditary. Tell Dr. May about the health of your immediate family members.

Family

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	○	○	_____	_____	○	○
Father	_____	○	○	_____	_____	○	○
Sister 1	_____	○	○	_____	_____	○	○
Sister 2	_____	○	○	_____	_____	○	○
Brother 1	_____	○	○	_____	_____	○	○
Brother 2	_____	○	○	_____	_____	○	○

19. Are there any other hereditary health issues that you know about? _____

_____

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Dr. Eric R. May

20. Social History

Tell Dr. May about your health habits and stress levels

Patient name

Social

Alcohol use	○ Daily	○ Weekly	How much? _____	Prayer or Meditation?	___	Yes	___	No
Coffee use	○ Daily	○ Weekly	How much? _____	Job Pressure/stress?	___	Yes	___	No
Tabacco use	○ Daily	○ Weekly	How much? _____	Financial peace?	___	Yes	___	No
Exercising	○ Daily	○ Weekly	How much? _____	Vaccinated?	___	Yes	___	No
Pain relievers	○ Daily	○ Weekly	How much? _____	Mercury fillings?	___	Yes	___	No
Soft Drinks	○ Daily	○ Weekly	How much? _____	Recreational drugs?	___	Yes	___	No
Water intake	○ Daily	○ Weekly	How much? _____					

Hobbies: _____

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/our of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderae Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? _____ **Hours**

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your perferred sleeping position? _____

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Consultation Notes

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shorest amount of time, please read each statement and initial your agreement.

Initials____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, 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 & distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials____ 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.

Initials____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials____ 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 extention of my care in this office.

Initials____ 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.

Initials____ 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 child, print child's full name: _____

Signature _____ Date (MM/DD/YYYY) _____

Doctor's Initials
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