Confidential Patient Information

Referred by whom? _____ SS#: _____

Name: _____ Age: _____ Birth date: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell #: _____

E-Mail Address: _____

Occupation: _____ Employer: _____ Marital Status: _____

Name of Nearest Relative: _____ Phone: _____

Name of Spouse: _____ # of Children: ___ Spouse's Occupation: _____

Spouse's Employer: _____ Date of Last Physical: _____

Briefly Describe Symptoms: _____

List All Other Doctors You Have Seen For This Condition: _____

_____ Describe any Operations and incl. Respective Dates:

_____

Serious Illness: _____

Insurance Data- Payment Arrangement Must Be Made On First Visit

Insurance Company Name: _____ Group #: _____ ID #: _____

Other Insurances (Incl. Spouse's Insurance Information)

Insurance Company Name: _____ Group #: _____ ID #: _____

I understand and agree that health and accident insurance policies between and insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account on receipt. THIS IS A DIRECT ASSIGNEMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I constitute and hereby appoint Dr. Jonathan W. McCullough and any of his duly authorized agents and employees to be the undersigned's true and lawful attorney for and in the undersigned's name, place, and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and said doctor which checks, drafts or money orders are to pay for the services or the like which have been or are performed by doctor at request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order. However, I clearly understand/agree that all services rendered me will be due and immediately payable. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due/payable. I hereby authorize the doctor to treat my condition as he deems appropriate through the use of manipulation/therapy. I hereby certify that I have read/fully understand the above Authorization for treatments, reason, advantage and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by the doctor. I also certify that no guarantee or assurance has been made as to the results that will be obtained. It is understood/agreed the amount paid to the doctor for x-rays, is for examination only and the x-ray negative will remain property of this office, ebbing on file where they may be seen at any time while a patient of this office. The medical center will not be held responsible for any pre-existing medical condition or for any medical diagnosis. Patient is responsible for all co-pays and deductibles.

Patient Signature: _____ Date: _____

Guardian Signature Authorizing Care: _____ Date: _____

JONATHAN WESLEY McCULLOUGH, D.C.
Board Certified in Rehabilitation
35 LAKESIDE DRIVE
LEVITTOWN, PENNSYLVANIA 19054-3901
(215) 946-0444
FAX 946-0448

I, _____, acknowledge that I have received from

_____Jonathan W. McCullough, D.C. their "Notice of Privacy Practices."

_____ _____

Patient's Name Date

_____ _____

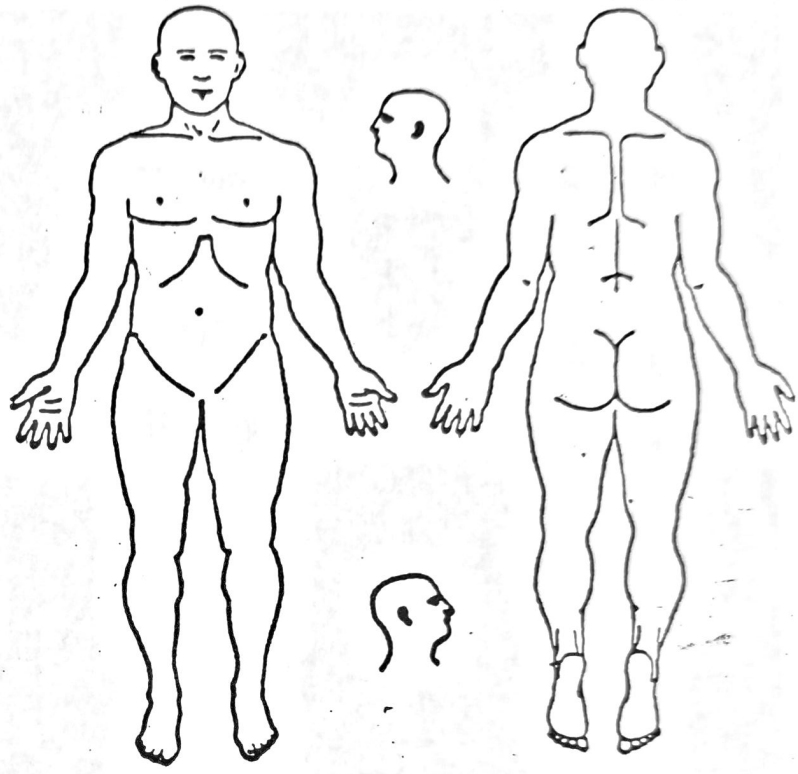
Witness Date

CONSULTATION

Name:_____ Age:_____ Date:_____

Please Read Carefully: Mark the affected areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbols listed below. And using the space provided next to the diagram, PLEASE WRITE A DETAILED DESCRIPTION OF YOUR SYMPTOMS IN YOUR OWN WORDS.

Ache >>>>>
Burning XXXX
Numbness = = = =
Stabbing //////
Pins &
Needles ooooo
Throbbing ~~~~



Please answer the following questions:

Where do you have pain?_____
When did you first begin to have pain?_____
Have you had this pain before?_____
Is your pain better or worse in the morning or night?_____
How often do you have pain?_____
What makes your pain worse?_____
What makes your pain better?_____
What other doctors have you seen for your pain?_____
Have any other doctors recommended surgery? Yes No
Are you taking medication for the pain? Yes No If so, what medications?_____

Do you smoke?_____ Time of last cigarette?_____
Do you have gout?_____ Diabetes?_____ Arthritis?_____
Have you had any fractures or surgery on your arms, legs, hands, or feet?_____

Patient's Signature_____

Please turn over and answer the questions on the back

Medical History

Date: _____

Name: _____ Birthdate: _____ Sex: _____ Race: _____

Health History of Patient

	YES	NO
Stroke	☐	☐
Heart Trouble	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Arthritis	☐	☐
Gout	☐	☐
Seizures	☐	☐
Mental Illness	☐	☐
Kidney Trouble or Stones	☐	☐
Cancer	☐	☐
Bleeding Disorders	☐	☐
Alcoholism	☐	☐
Serious Injuries	☐	☐
Lung Disease	☐	☐
Tuberculosis	☐	☐
Phlebitis	☐	☐
Anemia	☐	☐
Stomach Ulcers	☐	☐
Liver Trouble	☐	☐
Thyroid Trouble	☐	☐
Other Illnesses	☐	☐

Explain all Yes Answers:

_____

_____

_____

Surgical Procedures (include dates): _____

_____

_____

_____

Current Medications and Dosage: _____

_____

_____

_____

Allergies to Medicine: (☐ None)

_____

_____

_____

Family History

	YES	NO
Stroke	☐	☐
Heart Trouble	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Arthritis	☐	☐
Gout	☐	☐
Seizures	☐	☐
Mental Illness	☐	☐
Kidney Trouble or Stones	☐	☐
Cancer	☐	☐
Bleeding Disorders	☐	☐
Alcoholism	☐	☐
Other	☐	☐

Explain all YES answers:

_____

_____

_____

Cause of death of parents, or brothers, or sisters:

_____

_____

_____

Social History

Most Recent Occupation:

_____

Married ☐ Single ☐

Divorced ☐ Widowed ☐

Number of Children Living:

_____

Number of Pregnancies: _____

Presently living alone:

Yes ☐ No ☐

Smoke: ____ packs per day

Alcohol: Never ☐

Occasional ☐

Moderate to Heavy ☐

Drug Overuse: None ☐

Presently ☐ Past Problem ☐

Review of Systems

	YES	NO
Reading Glasses	☐	☐
Change of Vision	☐	☐
Loss of Hearing	☐	☐
Ear Pain	☐	☐
Hoarseness	☐	☐
Nosebleeds	☐	☐
Difficulty Swallowing	☐	☐
Frequent Cough	☐	☐
Shortness of Breath	☐	☐
Chills or Fever	☐	☐
Heart or Chest Pain	☐	☐
Abnormal Heartbeat	☐	☐
Badly Swollen Ankles	☐	☐
Calf Cramps with Walking	☐	☐
Poor Appetite	☐	☐
Nausea or Vomiting	☐	☐
Stomach Pain	☐	☐
Ulcers	☐	☐
Frequent Belching	☐	☐
Frequent Loose Bowels	☐	☐
Blood in Stools	☐	☐
Frequent Constipation	☐	☐
Hemorrhoids	☐	☐
Frequent Urination	☐	☐
Difficulty:		
-Starting Urination	☐	☐
-Stopping Urination	☐	☐
Mid-night urination	☐	☐
Frequent Headaches	☐	☐
Blackouts	☐	☐
Frequent Rash	☐	☐
Hot or Cold Spells	☐	☐
Recent weight change	☐	☐
Nervous Exhaustion	☐	☐
Insomnia	☐	☐
Depression	☐	☐
*Women Only:		
Irregular Period	☐	☐
Vaginal Discharge	☐	☐
Frequent Spotting	☐	☐