



The Maxwell Clinic
1000 Beltline Road, Suite V-1
Decatur, Alabama 35601

Dr. Phillip Maxwell, P.C.
(256) 350-1166

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. **THANK YOU**

Name _____ Social Security # _____
Address _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Cell# _____
Age _____ Birth date _____ Marital Status S M W D # Children _____
Occupation _____ Employed by _____
Nearest Relative & Phone # _____
Spouse's name _____ Spouse's Work Phone # _____
Referred to us by _____

**** HEALTH INFORMATION ****

What is your major complaint? _____

What caused condition? _____

When did this happen? _____ Have you had this or similar conditions in the past? Yes No

Is your current condition due to an auto accident or job related injury? Yes No

What activities aggravate your condition? _____

Is this condition getting progressively worse? Yes No Is condition Constant Comes & Goes

Is this condition interfering with your: Work Sleep Daily Routine Other _____

Do other family member have similar problems? Yes No Please list _____

Other doctors who have treated this condition _____

List other complaints (if any) _____

Date of last physical examination _____ Where? _____

Have you had previous chiropractic care? Yes No _____

Drugs you now take: None Nerve Pills Pain killers Muscle relaxers "Pep" pills

Tranquilizers Blood pressure Insulin Birth control Stomach pills

Age of mattress _____ Comfortable Uncomfortable

Are you wearing Heel lifts Sole lifts Inner soles Arch supports

Have you ever been in an auto accident? Past year Past 5 years Over 5 years Never

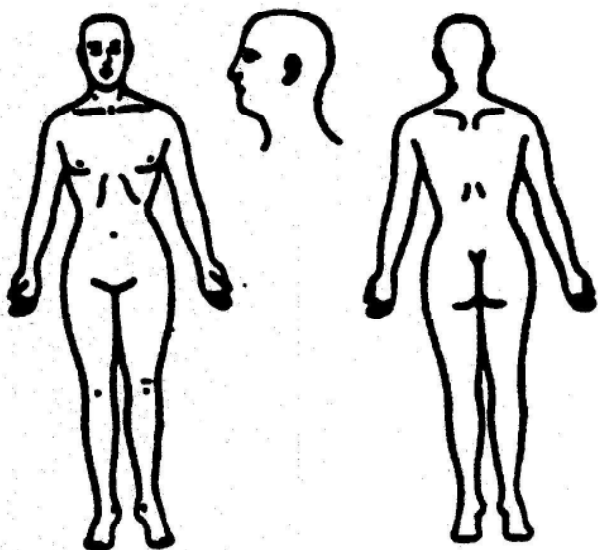
Describe _____

Have you had any other personal injury, job related injury or accident? Yes No

Describe _____

CONFIDENTIAL PATIENT CASE HISTORY

Please mark your areas of pain on figures below



Are You Currently Suffering From:

(check if yes)

- | | |
|---|---|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck pain/stiffness |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Pain between shoulders |
| <input type="checkbox"/> Fatigue | Pain/numbness in |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Shoulders |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Arms |
| <input type="checkbox"/> Loss of sleep | <input type="checkbox"/> Elbows |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Hands |
| <input type="checkbox"/> Nervousness/depression | <input type="checkbox"/> Hips |
| <input type="checkbox"/> Neuralgia | <input type="checkbox"/> Legs |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Knees |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Feet |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Painful tail bone |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Poor posture |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Foot trouble | <input type="checkbox"/> Spinal curvature |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Swollen joints |

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that The Maxwell Clinic 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 The Maxwell Clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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. I understand that certain information will be released in the event that it becomes necessary for The Maxwell Clinic to seek legal or collection procedures and that I will also be held responsible for any/all collection charges. These charges will be added to my bill.

I will be paying today by Cash Check Credit Card

MasterCard Visa Discover Card # _____ Exp. Date _____

All accounts not paid within 90 days will automatically be put through on your credit card.

Patient's Signature _____ Date _____

Guardian's Signature _____ SS# _____

PATIENT CONSENT FORM
ASSOCIATED FAMILY CHIROPRACTIC, PC
THE MAXWELL CLINIC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for ASSOCIATED FAMILY CHIROPRACTIC/THE MAXWELL CLINIC OF CHIROPRACTIC (AFC/MCC) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by AFC/MCC describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. AFC/MCC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Phillip Maxwell, 1000 Beltline Rd. Suite V-1, Decatur, AL 35601.

With this consent, AFC/MCC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, AFC/MCC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, AFC/MCC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that AFC/MCC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow AFC/MCC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, AFC/MCC may decline to provide treatment to me.

Signed by: _____
Signature of Patient or Legal Guardian Date Relationship to Patient

Print Patient's Name Print Name of Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

CONFIDENTIAL PATIENT HEALTH HISTORY

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. **THANK YOU**

Name _____ Date _____

Please check the appropriate box for any of the following symptoms which you "**currently have**" or "**previously have had**". We need all the facts about your health before we accept your case.

P-Previously Had	C-Currently Have
------------------	------------------

- | P | C | CONDITIONS |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Appendicitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Arteriosclerosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Chorea |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes (Type _____) |
| <input type="checkbox"/> | <input type="checkbox"/> | Diphtheria |
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever blisters |
| <input type="checkbox"/> | <input type="checkbox"/> | Goiter |
| <input type="checkbox"/> | <input type="checkbox"/> | Gout |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Influenza |
| <input type="checkbox"/> | <input type="checkbox"/> | Malaria |
| <input type="checkbox"/> | <input type="checkbox"/> | Measles |
| <input type="checkbox"/> | <input type="checkbox"/> | Miscarriage |
| <input type="checkbox"/> | <input type="checkbox"/> | Multiple sclerosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Mumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Pleurisy |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | Polio |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Scarlet fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Typhoid fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Whooping cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

RESPIRATORY

- | | | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficult breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Spitting up blood |
| <input type="checkbox"/> | <input type="checkbox"/> | Spitting up phlegm |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing |

P C GASTRO-INTESTINAL

- | | | |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Belching or gas |
| <input type="checkbox"/> | <input type="checkbox"/> | Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Colon trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficult digestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Distension of abdomen |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive hunger |
| <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids |
| <input type="checkbox"/> | <input type="checkbox"/> | Intestinal worms |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain over stomach |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting of blood |

EYES, EARS, NOSE & THROAT

- | | | |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Colds |
| <input type="checkbox"/> | <input type="checkbox"/> | Crossed eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Deafness |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental decay |
| <input type="checkbox"/> | <input type="checkbox"/> | Earache |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear noises |
| <input type="checkbox"/> | <input type="checkbox"/> | Enlarged glands |
| <input type="checkbox"/> | <input type="checkbox"/> | Enlarged thyroid |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Failing vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Far sightedness |
| <input type="checkbox"/> | <input type="checkbox"/> | Gum trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Hay fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Hoarseness |
| <input type="checkbox"/> | <input type="checkbox"/> | Nasal obstruction |
| <input type="checkbox"/> | <input type="checkbox"/> | Near sightedness |
| <input type="checkbox"/> | <input type="checkbox"/> | Nose bleeds |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore throat |
| <input type="checkbox"/> | <input type="checkbox"/> | Tonsilitis |

P C CARDIO-VASCULAR

- | | | |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hardening of arteries |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain over heart |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor circulation |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Slow heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling of ankles |

SKIN

- | | | |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Boils |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruise easily |
| <input type="checkbox"/> | <input type="checkbox"/> | Dryness |
| <input type="checkbox"/> | <input type="checkbox"/> | Hives or allergy |
| <input type="checkbox"/> | <input type="checkbox"/> | Itching |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin eruptions (rash) |
| <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins |

GENITO-URINARY

- | | | |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bed wetting |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Inability to control kidneys |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney infection or stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Pus in urine |

FOR WOMEN ONLY

- | | | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Congested breasts |
| <input type="checkbox"/> | <input type="checkbox"/> | Cramps or backache |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive menstrual flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot flashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular cycle |
| <input type="checkbox"/> | <input type="checkbox"/> | Menopausal symptoms |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful menstruation |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |

PLEASE PRINT

Have you ever had any mental or emotional disorders? Yes No When? _____

Have others in your family had such disorders? Yes No When? _____

HAVE YOU EVER:

	Yes	No	Describe Briefly
Been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Used a cane, crutch or other support?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been treated for a spine or nerve disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had a fractured bone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been hospitalized for anything other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had an allergic reaction to any drug/medication?	<input type="checkbox"/>	<input type="checkbox"/>	Please list _____ _____ _____

Please list all surgical operations that you have had

_____	Yr _____	_____	Yr _____	_____	Yr _____
_____	Yr _____	_____	Yr _____	_____	Yr _____
_____	Yr _____	_____	Yr _____	_____	Yr _____

Please list all medications and vitamins that you are presently taking

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DATE OF LAST:

Less than 6 months

6-18 months

Over 18 months

Never

Spinal Examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HABITS

Heavy

Moderate

Light

None

Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Signature _____ **Date** _____

Guardian's Signature _____ **SS#** _____