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

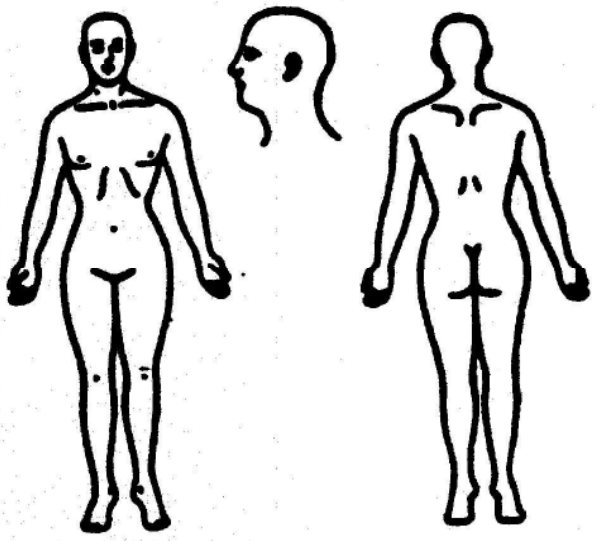
Describe _____

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)

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

INSURANCE INFORMATION

Do you have Health Insurance? ☐ Yes ☐ No If yes, _____
(Name Of Insurance Company)

Who is primary (check one) ☐ Myself ☐ Spouse ☐ Mother ☐ Father

If other than yourself, their: Full Name _____

Employer _____

Date of Birth _____ SSN _____

Are you covered by Medicare? ☐ Yes ☐ No Are you covered by Medicaid? ☐ Yes ☐ No

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
☐	☐	Alcoholism
☐	☐	Anemia
☐	☐	Appendicitis
☐	☐	Arteriosclerosis
☐	☐	Cancer
☐	☐	Chorea
☐	☐	Cold sores
☐	☐	Diabetes (Type ____)
☐	☐	Diphtheria
☐	☐	Eczema
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fever blisters
☐	☐	Goiter
☐	☐	Gout
☐	☐	Heart disease
☐	☐	Influenza
☐	☐	Malaria
☐	☐	Measles
☐	☐	Miscarriage
☐	☐	Multiple sclerosis
☐	☐	Mumps
☐	☐	Pleurisy
☐	☐	Pneumonia
☐	☐	Polio
☐	☐	Rheumatic fever
☐	☐	Scarlet fever
☐	☐	Stroke
☐	☐	Tuberculosis
☐	☐	Typhoid fever
☐	☐	Ulcers
☐	☐	Venereal disease
☐	☐	Whooping cough
☐	☐	Other_____
☐	☐	Other_____

RESPIRATORY

☐	☐	Chest pain
☐	☐	Chronic cough
☐	☐	Difficult breathing
☐	☐	Spitting up blood
☐	☐	Spitting up phlegm
☐	☐	Wheezing

P	C	GASTRO-INTESTINAL
☐	☐	Belching or gas
☐	☐	Colitis
☐	☐	Colon trouble
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Difficult digestion
☐	☐	Distension of abdomen
☐	☐	Excessive hunger
☐	☐	Gall bladder trouble
☐	☐	Hemorrhoids
☐	☐	Intestinal worms
☐	☐	Jaundice
☐	☐	Liver trouble
☐	☐	Nausea
☐	☐	Pain over stomach
☐	☐	Poor appetite
☐	☐	Vomiting
☐	☐	Vomiting of blood

EYES, EARS, NOSE & THROAT

☐	☐	Asthma
☐	☐	Colds
☐	☐	Crossed eyes
☐	☐	Deafness
☐	☐	Dental decay
☐	☐	Earache
☐	☐	Ear discharge
☐	☐	Ear noises
☐	☐	Enlarged glands
☐	☐	Enlarged thyroid
☐	☐	Eye pain
☐	☐	Failing vision
☐	☐	Far sightedness
☐	☐	Gum trouble
☐	☐	Hay fever
☐	☐	Hoarseness
☐	☐	Nasal obstruction
☐	☐	Near sightedness
☐	☐	Nose bleeds
☐	☐	Sinus infection
☐	☐	Sore throat
☐	☐	Tonsilitis

P	C	CARDIO-VASCULAR
☐	☐	Hardening of arteries
☐	☐	Heart Attack
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Pain over heart
☐	☐	Poor circulation
☐	☐	Rapid heart beat
☐	☐	Slow heart beat
☐	☐	Swelling of ankles

SKIN

☐	☐	Boils
☐	☐	Bruise easily
☐	☐	Dryness
☐	☐	Hives or allergy
☐	☐	Itching
☐	☐	Skin eruptions (rash)
☐	☐	Varicose veins

GENITO-URINARY

☐	☐	Bed wetting
☐	☐	Blood in urine
☐	☐	Frequent urination
☐	☐	Inability to control kidneys
☐	☐	Kidney infection or stones
☐	☐	Painful urination
☐	☐	Prostate trouble
☐	☐	Pus in urine

FOR WOMEN ONLY

☐	☐	Congested breasts
☐	☐	Cramps or backache
☐	☐	Excessive menstrual flow
☐	☐	Hot flashes
☐	☐	Irregular cycle
☐	☐	Menopausal symptoms
☐	☐	Painful menstruation
☐	☐	Vaginal discharge

☐Yes ☐No 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?	☐	☐	_____
Used a cane, crutch or other support?	☐	☐	_____
Been treated for a spine or nerve disorder?	☐	☐	_____
Had a fractured bone?	☐	☐	_____
Been hospitalized for anything other than surgery?	☐	☐	_____
Had an allergic reaction to any drug/medication?	☐	☐	**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	☐	☐	☐	☐
Spinal X-ray	☐	☐	☐	☐
Physical Examination	☐	☐	☐	☐
Blood Test	☐	☐	☐	☐
Urine Test	☐	☐	☐	☐
Chest X-ray	☐	☐	☐	☐
Dental X-ray	☐	☐	☐	☐

SOCIAL HABITS	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Patient's Signature _____ Date _____

Guardian's Signature _____ SS# _____