Welcome to McGuire Chiropractic Health Center!

We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems. Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions.

	ird to serving you.		
Name Age	Reason for today's visit		
Address			
CityStateZip	When did this condition begin?		
Cell # SS #	Describe		
Email			
Birthdate M/F Marital Status	What activities aggravate your symptoms?		
Type of work/employer			
Do you have children? Ages	Does anything relieve your symptoms?		
Do you notice poor postural habits in your kids?			
How were you referred to this office?	Have you experienced this condition before?		
Emergency contact	Who treated you for this condition?		
Emergency contact's phone #	How did you respond?		
Emergency contact 3 priorie #			
Please, mark your area(s) of pain on the following figures and rate the average intensity on the scale.	Worst pain (10) Least pain (0)		
	ho? When?		
Reason for visits How did you respond?			
Are you aware of any of your poor postural habits?	n) The most common postural weakness is Forward		
Head Syndrome (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse effects on your overall health.			
Do you exercise? How often? Do you smoke? How often?			
Do you drink alcohol? How often? Do you drink coffee? How often?			
Do you take any supplements (vitamins, minerals, herbs)?			

your spine. This results in a weakened and distorted posture. Postural distortions have many serious and adverse effects on your overall health. CERVICAL SPINE (NECK): Postural distortion from subluxations, causing forward head syndrome, in your neck will weaken the nerves into your arms, hands and head and affect these parts of your body. Do you experience? Neck pain Pain into your Headaches Numbness/tingling in Dizziness Recurrent Colds/Flus Numbness/tingling in Visual disturbances Hearing disturbances Thoracic Spine (Upper Back): Postural distortion from subluxations, resulting from forward head syndrome, in the upper back will weaken the nerves and adverged from syndrome and adverged from syndr	Abnormal postural habits or distortions are the result of trauma or stress to the body that have misaligned the vertebrae in your spine. When these vertebrae are twisted from their normal position, they will cause stress to the spinal cord and the delicate nerves that pass between the vertebrae. These misalignments are called subluxations . It has been extensively documented that subluxations, causing stress to your nerves, will weaken and distort the overall structure of					
CERVICAL SPINE (NECK): Postural distortion from subluxations, causing forward head syndrome, in your neck will weaken the nerves into your arms, hands and head and affect these parts of your body. Do you experience? Neck pain Weakness in grip Sinusitis Pain into your Headaches Allergies/Hay fever shoulders/arms/hands Dizziness Recurrent Colds/Flust Numbness/tingling in Visual disturbances Low energy/Fatigue arms/hands Coldness in hands TMJ/Pain/Clicking Hearing disturbances Thyroid conditions	rse					
arms, hands and head and affect these parts of your body. Do you experience? Neck pain Weakness in grip Sinusitis Pain into your Headaches Allergies/Hay fever shoulders/arms/hands Dizziness Recurrent Colds/Flust Recurrent Colds/Flust Low energy/Fatigue arms/hands Coldness in hands TMJ/Pain/Clicking Hearing disturbances Thoracic Spine (Upper Back):	CERVICAL SPINE (NECK):					
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□ Pain into your □ Headaches □ Allergies/Hay fever shoulders/arms/hands □ Dizziness □ Recurrent Colds/Flus □ Numbness/tingling in arms/hands □ Visual disturbances □ Low energy/Fatigue □ TMJ/Pain/Clicking □ TMJ/Pain/Clicking □ Hearing disturbances □ Thyroid conditions						
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arms/hands						
☐ Hearing disturbances ☐ Thyroid conditions THORACIC SPINE (UPPER BACK):						
THORACIC SPINE (UPPER BACK):						
	erves					
to the heart and lungs and affect these parts of your body. Do you experience?	CIVCS					
☐ Heart palpitations ☐ Recurrent lung ☐ Pain on deep						
☐ Heart murmurs infections/bronchitis inspiration/expiration	n					
☐ Tachycardia ☐ Asthma/wheezing	11					
☐ Heart attacks/Angina ☐ Shortness of breath						
THORACIC SPINE (MID BACK):						
Postural distortion from subluxations , resulting from forward head syndrome , in the mid back will weaken the ner	200					
into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience?	VC3					
☐ Mid back pain ☐ Tired/irritable after eating ☐ Nausea						
☐ Pain into your ribs/chest or when you haven't ☐ Ulcers/gastritis						
☐ Indigestion/heartburn eaten for a while ☐ Hypoglycemia ☐ Reflux						
., -,						
LUMBAR SPINE (LOW BACK): Destural distortion from subluvations, resulting from forward head syndroms, in the low back will weaken the nor						
Postural distortion from subluxations , resulting from forward head syndrome , in the low back will weaken the ner	ves					
into your legs/feet and pelvic organs, and affect these parts of your body. Do you experience?						
□ Low back pain □ Muscle cramps in your □ Frequent/difficulty						
Pain into your legs/feet urinating	_					
hips/legs/feet	:a					
□ Numbness/Tingling in hips/knees/ankles □ Menstrual						
your legs/feet	ng					
☐ Coldness in your legs/feet infections (females)						
☐ Sexual dysfunction						
Please list any health conditions not mentioned.						
Please list any medications/surgeries.						
Please list any traumas.(falls, car accidents, etc.)						
All of the information provided above is accurate and true to the best of my knowledge.						
Patient Signature Date						

PAYMENT/INSURANCE AGREEMENT

In consideration of your undertaking and care of me, I agree to the following:

YOU ARE RESPONSIBLE FOR COMMUNTICATION WITH YOUR INSURANCE COMPANY AND UNDERSTANDING YOUR HEALTH INSURANCE

If for any reason my account is delinquent for over 30 days, I hereby authorize McGuire Chiropractic to collect the full amount from my credit card account listed below, along with a 3% office fee (i.e.: \$55 balance will result in a charge of \$56.65 total charge to my credit card).

OR

In the event my insurance company forwards payment for services rendered at your office directly to me (specifically Blue Cross and Blue Shield Members) I will be responsible to render such payments to McGuire Chiropractic, along with the Explanation of Benefits that was provided to me, within 10 days. Even if the Explanation of Benefits is a "0" balance/payment I will either mail/bring in or send you a picture of that EOB as soon as I receive it, to avoid being charged for the office visit.

If for any reason I do not issue McGuire Chiropractic the original payment or a personal payment within 10 days, I hereby acknowledge my account will be in a delinquent status.

If I choose not to provide my credit card information to avoid such matters, I hereby acknowledge that my information will be forwarded to an outsourced collection agency, which will affect my credit. I understand that McGuire Chiropractic will take aforementioned action if I do not contact them to arrange a payment within 30 days of my delinquent status. If I provide my credit card information to McGuire Chiropractic and the payment is declined for any reason I understand I will have five business days to forward a new form of payment to your office, if not, I am aware that you will send me to collections.

OR

If I choose not to provide my credit card information to avoid such matters, I hereby acknowledge that I WILL BE CONSIDERED A CASH PATIENT and I understand that I can submit to my insurance company directly.

Responsible party for insurance payments:

Name:	Relationship:			
Address				
Credit Card: MasterCard	Visa	American Express	HSA	Discove
Card Number:			Security Code:	
Expiration Date:				
Patient signature:			Date:	

PATIENT AUTHORIZATION REGARDING OUR OPEN DOOR ADJUSTING ENVIRONMENT, SIGN-IN SHEETS, TRAVEL CARD USE AND PATIENT RECORD OF DISCLOSURES

Our office uses sign-in sheets, travel cards, and provides care in an "open-door" adjusting environment. Adjustments are done in an open adjusting area as a result patients are in sight of each other and some on going routine details of care may be overheard by other patients and/or staff. This environment is used for on going care and is not the environment for taking patients histories, performing examinations or presenting report of findings. These procedures are done in a private, confidential setting. If you choose not to be adjusted in an open-door adjusting environment, other arrangements will be made for you. Your signature below indicates your authorization for this activity.

In addition, your signature below authorizes us to contact you at all the phone numbers/addresses you list on this intake form. If you do not wish to be contacted at any listed numbers/address, please let us know.

Patient's Signature:	Date:
Privacy Policy Received	
Patient's Signature Date:	Date:
CONSENT FOR PURPOSES OF TREATMEN	T, PAYMENT, AND HEALTH CARE OPERATIONS
created or received by my physician. This protected healt mental health or condition and identifies me, or there is a I consent to the use or disclosure of my protected diagnosing or providing treatment to me, obtaining payme of McGuire Chiropractic. I understand that Dr. McGuire m or disclosure of my protected health information for the a I understand I have the right to request a restriction to carry out treatment, payment or health care operation	ion, including demographic information, collected from me and h information relates to my past, present, or future physical or reasonable basis to believe the information may identify me. nealth information by McGuire Chiropractic, for the purpose of ent for my health care bills or to conduct health care operations any refuse to diagnose or treat me, if I do not consent to the use bove-stated purposes. as to how my protected health information is used or disclosed s of the practice. McGuire Chiropractic is not required to agree Chiropractic agrees to a restriction that I request, the restriction
me) prior to signing this document. The Notice of Privar protected health information that will occur in my treatmoperations of McGuire Chiropractic. The Notice of Privacy	practic's Notice of Privacy Practices (which has been provided to acy Practices describes the type of uses and disclosures of my ment, payment of my bills, or in the performance of health care a Practices for McGuire Chiropractic is also provided on request as also describes my rights and McGuire Chiropractic's duties with
	privacy practices that are described in the Notice of Privacy Chiropractic's office and request a revised copy be sent in the .
I have a right to revoke this consent in writing, at a McGuire has taken reliance on this consent.	ny time, except to the extent that McGuire Chiropractic or Dr.

Date:____

Patient/Guardian Signature:

REMINDER OPTIONS

McGuire CHC is an easy-going stress free zone. To make things as convenient as possible for our patients, we offer two options for appointment reminders. Please check which option you prefer.

	Phone Number
□ Please	text me to remind me of my appointments
□ Please	call me to remind me of my appointments

If you should miss an appointment, we will use your preferred choice of contact to reschedule the appointment.

Most smartphone plans have unlimited texting. If your plan does not have this feature, standard text messaging rates will apply.

Patient Photo and Testimonial Release Information

l,	, authorize Dr. Tom McGuire, D.C. to use
my photo for advertisement and/or public r	
newspaper, patient newsletters, websites,	internet, Facebook, YouTube, Instagram,
social media, and/or mailings, etc.	
My statements are given freely and withou editing as needed for adaptation for differe	at any coercion or incentive. I agree to allow ent Medias.
I understand that I may revoke my permiss anytime and will notify Dr. Tom McGuire, D	sion to use my personal health information at D.C. in writing.
Name (Print):	
Signature:	Date:
Witness:	Date: