

MCCRACKEN CHIROPRACTIC CLINIC

5740 Old Cheney Rd, Ste 16, Lincoln, NE 68516 ▪ Ph (402) 421-2277 Fax (402) 421-7386

New Patient Information

Name: _____ Home Phone: _____ Cell: _____

Address: _____

City, State, Zip: _____

Social Security #: _____ Birth Date: _____ Age: _____

Number of Children: _____ Marital Status: M S W D Spouse's Name: _____

Occupation: _____ Employed By: _____

Work Phone: _____ Address: _____

Spouse's Occupation: _____ Employer: _____

Name of Nearest Relative: _____ Phone: _____

Address: _____

How were you referred to this office? _____

Have you ever had chiropractic care before? Y N If so, when? _____

List your main complaints in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

List other doctors consulted for this condition:

1. _____ Address: _____
2. _____ Address: _____

NOTICE:

Not all patients require x-rays to determine or verify a diagnosis, type of treatment or length of treatment. If your examination warrants x-ray analysis the following policy prevails:

1. All first day visit charges are payable when service is rendered.
2. The fee paid for treatment x-rays is for analysis only. The film is the property of this office. Films can be released temporarily to other health professionals.

Method of payment you plan to use to take care of today's charges:

Check ___ Cash ___ VISA ___ MasterCard ___ Discover ___

Do you have health insurance? Y N Company: _____

Address: _____ Policy # _____

Are you covered under any other policy through yourself or spouse? Y N If yes, company

Name: _____ Address: _____

Spouse's Social Security #: _____ Birth Date: _____

Patient's Signature / Guardian: _____ Date: _____

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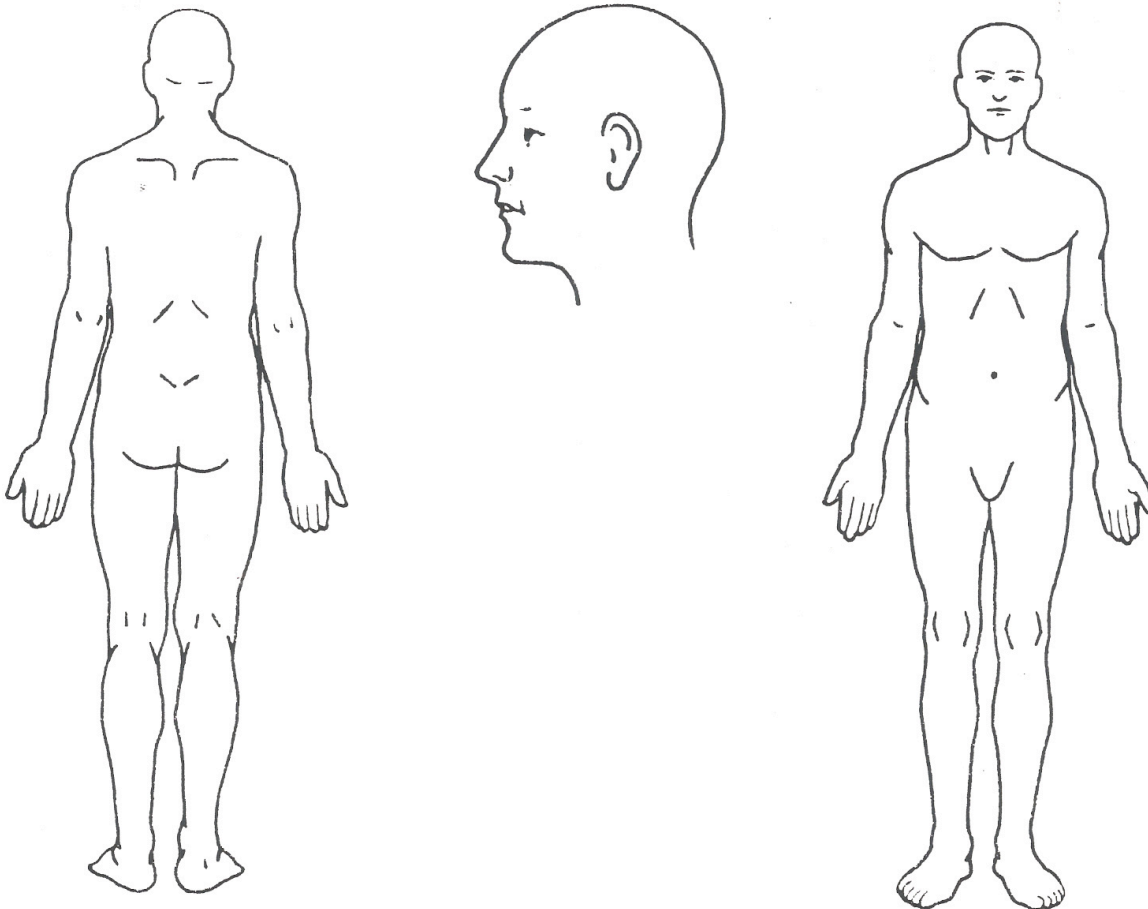
Pain Drawing

Name: _____

Date: _____

Please fill out this drawing according to where your pain is. Use the appropriate symbols and mark the areas of pain.

Numbness **OOO** Pins / Needles **---** Stabbing **///** Burning Pain **xxx** Aching **+++**



On a scale of 1-10 check off your current pain level.

Normal	Low	Moderate	Intense	Emergency
<input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> 4	<input type="checkbox"/> 7	<input type="checkbox"/> 10
	<input type="checkbox"/> 2	<input type="checkbox"/> 5	<input type="checkbox"/> 8	
	<input type="checkbox"/> 3	<input type="checkbox"/> 6	<input type="checkbox"/> 9	