



MCLAUGHLIN CHIROPRACTIC CENTER

PLEASE FILL THIS OUT COMPLETELY AND RETURN WITH YOUR CURRENT
INSURANCE CARD FOR US TO COPY.
PATIENT INFORMATION UPDATE

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INS. INFO REC. _____
INS. INFO VERIFIED _____
NO INSURANCE _____

Today's Date _____ Last Visit _____ Last X-rays _____ Pt. # _____

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ SS# _____ - _____ - _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address _____
(Please use the exact upper or lower case letters)

Street Address and Number _____

Mailing Address (if different) _____

City, State, and Zip _____

Circle One: Married Single Widowed Divorced # of Children: _____

Employer: _____ Occupation: _____ Supervisor: _____

Employer Address _____

Where/what is the problem that brings you to us today? _____

If we've treated this problem before, is it exactly the same? Yes No
If no, how is it different? _____

Has this problem resulted from a NEW accident or injury? Yes No
Describe: _____

Have you seen another doctor since your last visit: Yes No
If yes, who did you see and the reason _____

Are you taking any medication? Yes No
If yes, what are you taking _____

Have you had surgery since your last visit? Yes No
If yes, please explain _____

Patient Signature: _____ Date: _____

"Helping Build A Healthier Community."

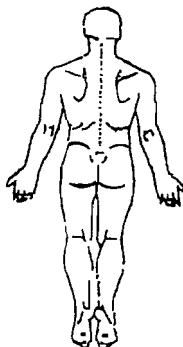
Patient Name: _____ Patient ID# _____ Date: _____

History/Description of Present Condition:

1. History:

Patient's symptoms and indicate symptom pattern on diagram. _____

Place (x) on areas of Pain:



2. Other Complaints: (Please Circle)

Neck Pain Mid Back Pain Lower Back Pain Rt. Arm Pain Left Arm Pain Rt. Leg Pain
Left Leg Pain Headaches Other: _____

3. What caused the pain? (Injury, accident, unknown cause etc.): _____

4. Quality/Character of spine symptoms:

Sharp Dull Aching Shooting Numbness Burning Radiating

5. Onset: _____ Sudden _____ Gradual _____

Rate intensity of Pain/Symptom: No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Ever

Frequency: Constant? (All the time) _____ Episodic? (Comes and goes): _____

6. Aggravating Factors (Does any activity make it worse?) _____ Relieving Factors: _____

7. Related Past Health History/Surgery/Medications: _____

8. Prior Care for this problem: _____

Patient Signature

Date