Mulcahy Chiropractic

704 Main Street Falmouth, MA 02540 — 508-457-0440
16B Amelia Drive Nantucket, Ma 02554 — 508-228-2200

Personal information

Name: ______________________________
Permanent Address: ______________________________
City/State/ Zip: ______________________________
Local Address: ______________________________
Date of Birth: ____________ Age ________
Marital Status: S M D W
Occupation: ______________________________

Home Phone: ______________________
Work Phone: ______________________
Cell Phone: ______________________
SS# : ______________________
Email: ______________________
# of Children _____ Ages ______________
Referred By: ______________________

Health Information

Reason for consulting our office? ______________________________

How and when did this occur? ______________________________

Please explain how this affects your life ______________________________

Please list any/all hospitalizations or surgeries you have had. ______________________________

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Are you presently taking any prescription or over the counter medication(s)? ______________________

How many? ____________ What for? ______________________________

Have you had previous chiropractic care? YES NO When________ Duration of care ______________

For woman: Are you pregnant? YES NO

What are your goals? ________ Relief Care ________ Corrective ________ Wellness Care

Do you have the following chronic problems?

- [ ] Diarrhea
- [ ] Constipation
- [ ] Heartburn
- [ ] High Blood Pressure
- [ ] Heart Disease
- [ ] Congestion
- [ ] Thyroid problem
- [ ] Dizziness
- [ ] Forgetfulness
- [ ] Confusion
- [ ] Depression
- [ ] Asthma/Allergies
- [ ] Ear Aches
- [ ] Sinus Trouble
- [ ] Cancer
- [ ] Diabetes
- [ ] Arthritis
- [ ] Reproductive System
- [ ] Mental Disorder
- [ ] Menstrual Irregularity
- [ ] Eczema
- [ ] Trouble Urinating
- [ ] Fibromyalgia
- [ ] Multiple Sclerosis
- [ ] Trouble Sleeping
- [ ] Epilepsy
- [ ] Gallbladder Problems
- [ ] Other undiagnosed problem

Payment and Insurance Information

* Payment is expected at the time of services.
** I understand that having health insurance is not a guarantee of coverage or payment for services I may receive. <u>I understand that I am ultimately responsibility for payment</u>. Furthermore, I authorize Mulcahy Chiropractic P.C. to submit claims to my insurance company for all services provided to me. In the event that my insurance company reimburses me instead of Mulcahy Chiropractic P.C., I will turn those payments over to Mulcahy Chiropractic.

Signature______________________________ Date______________
Parents name (if patient is a minor) ______________________my signature above authorizes this office and its doctors to administer care to my child. Furthermore, I understand as the parent/guardian that I am personally responsible for payment of fees charged by this office.