McCAFFREY *Family Health Center*

Sean E McCaffrey D.C., IHS, LDHS
Internal Health Specialist
3330 Hedley Road, Suite C
Springfield IL 62711
217.726.0151

BASIC INFORMATION

TODAY'S DATE __/__/____

FULL NAME _____

DATE OF BIRTH __/__/____

WHAT MAIN REASON BRINGS YOU IN TO SEE OUR TEAM TODAY? _____

_____

_____

_____

CURRENT PHYSICAL CONDITION

WHAT IS (ARE) YOUR MAJOR CONCERN(S) ABOUT YOUR HEALTH? LIST THEM.

_____ _____ _____

_____ _____ _____

HOW ARE THESE HEALTH CONDITIONS/CONCERNS AFFECTING YOUR LIFE? _____

_____

HOW LONG HAS IT BEEN SINCE YOU HAVE REALLY FELT GOOD?_____

_____

GOALS AND EXPECTATIONS

IF YOU COULD CHANGE ONE THING ABOUT YOUR PHYSICAL HEALTH WHAT WOULD IT BE?

_____

AND YOUR EMOTIONAL HEALTH? _____

AND YOUR NUTRITIONAL (CHEMICAL) HEALTH? _____

WHAT ARE YOUR EXPECTATIONS FROM OUR TEAM AT MFHC? _____

WHAT ARE YOUR WELLNESS GOALS/EXPECTATIONS THAT YOU WOULD LIKE TO ACCOMPLISH?

_____

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HEALTH HISTORY

CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

__ACNE
__ANEMIA
__ARTHRITIS
__ARTIFICIAL BONES/JOINTS
__ARTIFICIAL VALVES
__ASTHMA
__CANCER
__CHEMOTHERAPY
__CHRONIC BAD BREATH
__CONGENITAL HEART DEFECT
__DEPRESSION
__DIABETES
__DIFFICULTY BREATHING
__EMPHYSEMA
__FAINTING/SEIZURES
__FREQUENT NECK/BACK PAIN
__GLAUCOMA
__HEART ATTACK/STROKE
__HIGH BLOOD PRESSURE
__LOW BLOOD PRESSURE
__LYME DISEASEE
__SEVERE/FREQUENT HEADACHES
__SINUS PROBLEMS
__SKIN CONDITIONS
__ULCERS/COLITIS
__OTHER:_____

LIFESTYLE

CHECK MARK THOSE THAT APPLY TO YOU:

EXERCISE	***WORK ACTIVITIES***	***STRESST LEVEL***
__NONE	**__MOSTLY SITTING**	**__NONE**
__MODERATE	**__MOSTLY STANDING**	**__LOW**
__DAILY	**__LIGHT LABOR**	**__MODERATE**
__HEAVY	**__HEAVY LABOR**	**__HIGH**

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I, _____, hereby declare that all information I provided is true and current to the best of my knowledge. I recognize McCaffrey Family Health Center's ability to provide the best care possible and give them permission to advise and treat me accordingly as well as obtain payment for the treatment in order to carry out its health care operations.

I also acknowledge that McCaffrey Family Health Center will keep all of my information private according to the required Health Insurance Portability and Accountability Act (HIPAA) policy. The McCaffrey Family Health Center's Privacy Notice contains all guidelines to protecting my information and I am aware that I can request to read it at any time. It is provided at the front desk for my convenience. I acknowledge that McCaffrey Family Health Center reserves the right to change its privacy practices that are described in the Privacy Notice, in accordance with applicable law.

I have read and understand the foregoing notice and all of my questions have been answered to my full satisfaction in a way that I understand it.

_____ ____/____/_____

Patient name (please print) **Today's date**

_____ _____

Patient signature **OR** **Signature of legal representative**

_____

Relationship