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# McGill Method

## Personal Information

Full name _____ Name you wish to be called _____

Street Address _____

City _____ State _____ Zip _____

Phone: Mobile) _____ E-Mail: _____

Date of birth ____/____/____ Gender: M Insurance Company: _____

Occupation: _____ Employer: _____

Who were you referred by? _____

Person to contact in case of emergency _____ Phone _____

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## Primary Concern

What brings you to my office? _____

_____

_____

Date of original condition: _____ Date of most recent occurrence: _____

Was there an event that created the condition? _____

Have you had this or similar conditions in the past? _____

What makes it better? _____ Worse? _____

Is the condition getting worse? _____Constant? _____

Worse at a certain time of day?_____

Is this condition interfering with: Work? _____Sleep? _____ Activity? _____Other? _____

Please list your goals for treatment, (immediate and future), and if you are also concerned with optimizing your overall health and well-being.

_____

_____

_____

## Health History

List other current health issues & problems: _____

_____

_____

List other practitioners seen, treatments, self-care activities, and results:_____

_____

_____

_____

List illness you have had not previously mentioned, if any: _____

_____

List all surgeries you have had, with dates and results: _____

_____

_____

Have you ever been in an accident or seriously injured? (if so, please describe)_____

_____

_____

List all medications, vitamins, herbs and other supplements you are now taking, the dose, and reason for taking (please bring actual bottles w/pills in with you to your appointment):

_____

_____

_____

_____

List all medications and other substances (i.e.: foods) to which you are allergic: _____

_____

## Family History

Please list age(s) and health problems (if any); if deceased, please list age at death and cause of death:

Father _____ Mother_____ Children_____

Grandparents _____ Brothers _____ Sisters_____

## General

*Describe your use of: Cigarettes/Tobacco _____Alcohol _____ Other drugs_____

*Describe your present exercise habits including frequency per week, duration, and heart rate: _____

_____

_____

* How many hours per night do you sleep? ____ * Do you fall right asleep? Y N * Do you wake up feeling refreshed? Y N

* Do you sleep through the night without awaking? Y N * Do you remember your dreams? Y N

* Do you snore? Y N *Do you have nightsweats? Y N * Do you have nightmares? Y N

* Do you grind your teeth at night (bruxism)? Y N * Do you have restless legs (RLS)? Y N

*When did you last receive the following (leave blank if it does not apply to you), (please remember to bring copies).

*Cholesterol or other blood tests _____

* Prostate Exam _____*Other_____

## Pain Questionnaire

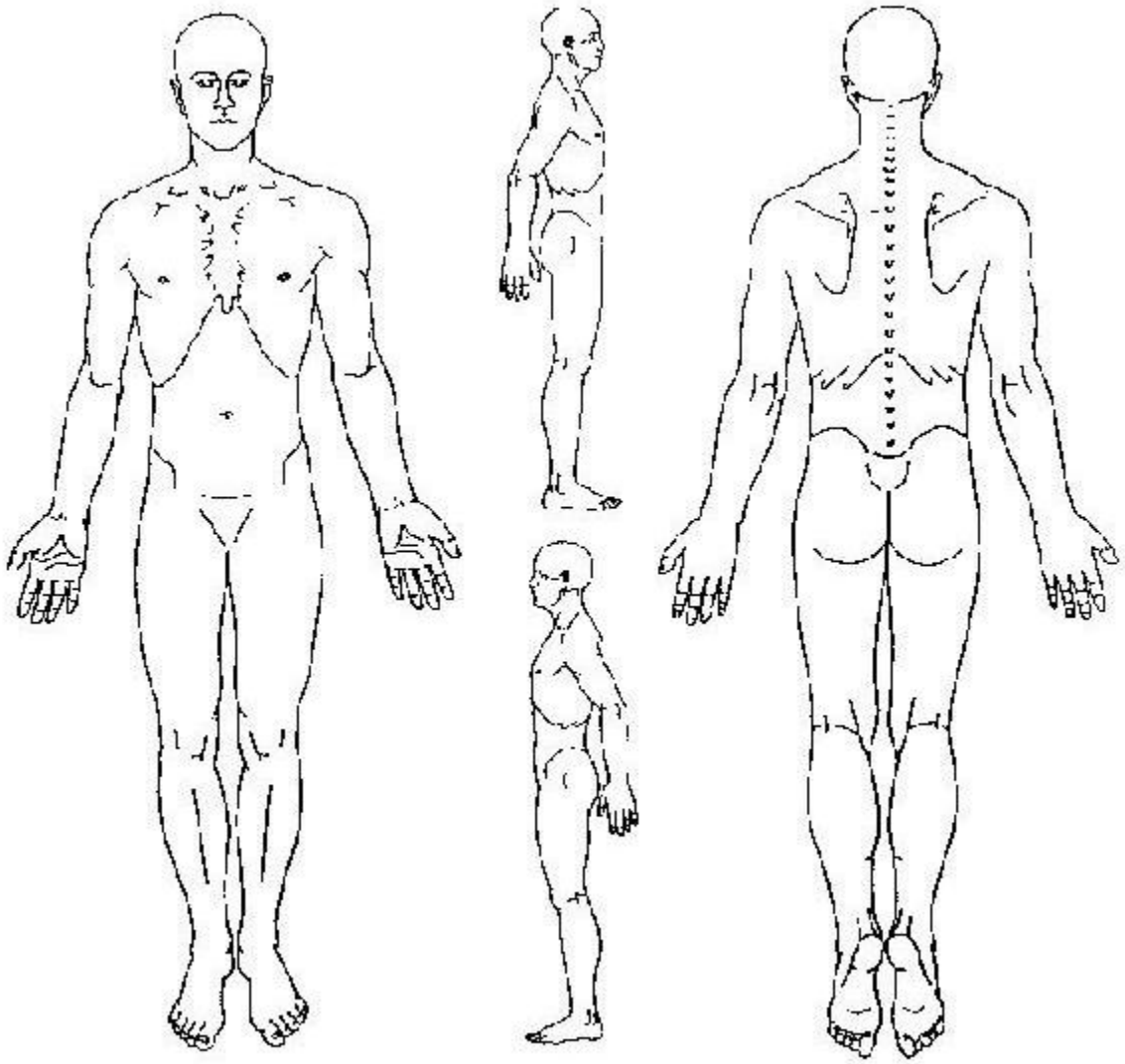
(Skip to the next section if you are not currently experiencing pain.)

**Please place a single vertical line through the scale below at the point that best describes your pain. (0 is no pain, 10 is the worst pain imaginable)**

**0.....|.....|.....|.....|.....|.....|.....|.....|.....|.....10**

**Place the letters listed below on the diagrams to indicate the type and location of your current sensations.**

| | | | |
|---|---|---|---|
| **A = Ache** | **B = Burning** | **N = Numbness** | **O = Other** |
| **P = Pins & Needles** | **S = Stabbing** | **T = Throbbing** | |



## History of Injury

Please mark with an "X" **all the places on your body which have ever been injured** (sprains, strains, broken bones, scars from surgeries or accidents, severe bruises, falls, etc.). Please also include any tattoos and piercings, other than ear.