MOORECHIROPRACTIC

Patient Information

Name _____ Phone _____
Address _____ City _____ State _____ Zip _____
Employer/Occupation _____ Race _____ Sex: Male / Female
Date of Birth _____ Height _____ Weight _____ Blood Pressure (if known) _____
Marital Status (circle one): Single / Married (Spouse's Name _____)

- If married, would you like your spouse to be able to obtain records from this office on your behalf? Yes / No

Health Insurance Information

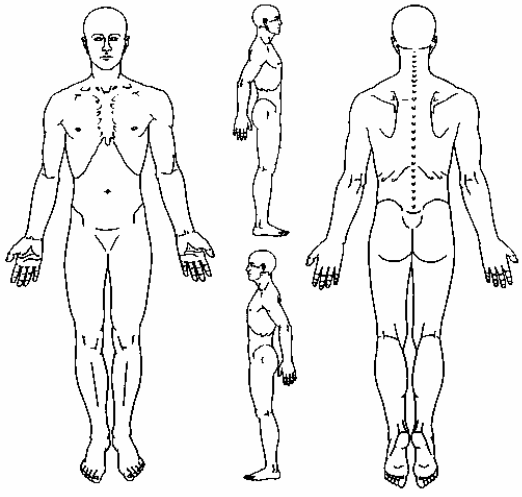
Company _____ ID Number _____ Primary / Dependent

Status of Current Complaint

Statement of problem, symptoms, or condition (be specific): _____
_____
_____
Date condition originally began _____ Date of this episode _____ Was it gradual? Yes / No
Is your condition due to work comp? Yes / No Auto Accident? Yes / No Other Trauma/Injury? Yes /No
List any other health care providers visited for this condition and the outcome of treatment _____
_____

Location, Type, and Severity of Pain

Please circle the area of symptoms on the drawings below and circle the corresponding symptom description to the right.



Circle All That Apply

Numbness

Pins and Needles

Burning

Stabbing

Throbbing

Ache

Other_____

What activities increase your pain? _____
What activities decrease your pain _____

Pain Rating (0-10 Scale)

Pain level currently (circle one): 0 1 2 3 4 5 6 7 8 9 10
Pain level at worst (circle one): 0 1 2 3 4 5 6 7 8 9 10
Pain level at best (circle one): 0 1 2 3 4 5 6 7 8 9 10
Average pain level (circle one): 0 1 2 3 4 5 6 7 8 9 10

Medical History (If you need more space, use the back of this form)
Please list any diseases/health conditions: _____
_____
_____

Have you ever had a stroke, spinal fracture/dislocation, spinal surgery, or joint replacement? Yes / No
- If yes, please specify: _____
_____
_____

Have you previously been hospitalized? Yes / No
- If yes, please specify: _____
_____
_____

Have you had any other previous surgeries not listed above? Yes / No
- If yes, please specify: _____
_____
_____

Are you taking any prescription medications? Yes / No
- If yes, please specify: _____
_____
_____

Medical Doctor/Primary Care Physician: _____

Social History
Do you smoke? Yes / No Do you use smokeless tobacco? Yes / No How Long? _____

Referral Source
How did you hear about our clinic? If another patient referred you to our clinic, please list their full name:
_____

Authorization and Consent to Treatment
- I affirm that all information given in this form is true, complete, and accurate.
- I understand that Moore Chiropractic is a cash practice, and I am required to pay for services at the time they are rendered. Although Moore Chiropractic will file certain insurance claims as a courtesy on my behalf, I understand that reimbursement disputes are ultimately between my insurance provider and I.
- I understand that Moore Chiropractic is solely focused on the detection and reduction of subluxations (segmental dysfunctions) and that I will be referred to an appropriate medical professional if any non-chiropractic findings are encountered during my examination or treatment.
- I understand that based on the current standard of chiropractic care, medical imaging is not indicated for new patients unless certain red flag symptoms are present. If my condition does not show improvement within a reasonable timeline, I may be referred out for medical imaging at a later date.
- I acknowledge that no assurance was offered about the outcome of my care.
- I release Moore Chiropractic from any responsibly in the case of accident, illness, or injury.
- I acknowledge that I have received, reviewed, and understand the Notice of Privacy Practices which describes the clinic's policies and procedures regarding the use and disclosure of any protected health information received, created, or maintained in the clinic.

Signature _____ Date _____