MOORECHIROPRACTIC

General Patient Information

Name _____ Social Security # _____ Date _____
Address _____ City _____ State _____ Zip _____
Primary Phone _____ Secondary Phone _____ Email _____
Employer _____ Race _____ Sex: Male / Female
Date of Birth _____ Age _____ Height _____ Weight _____ Blood Pressure _____
Marital Status (circle one): Single Married (Spouse's Name _____) Divorced Widowed

Health Insurance Information

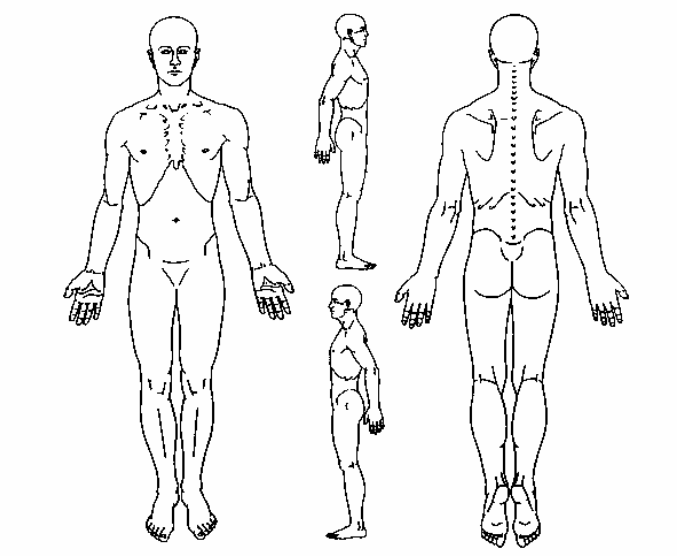
Company _____ ID Number _____ Primary / Dependent
I authorize Moore Chiropractic to file claims with my insurance company. _____ (sign)

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? _____ Auto Accident? _____ Other Trauma/Injury? _____
List any other health care providers visited for this condition and 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.



Numbness Pins and Needles Burning

Stabbing Throbbing Ache

General Pain Other_____

On a scale of 0 to 10, rate your:
Pain level currently _____
Pain level at worst _____
Pain level at best _____
Average pain level _____

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

Past Medical History

List diseases or health conditions _____
_____
List all drugs/medications and **dosages** you are currently taking _____
_____
_____

List all drug allergies _____
List all hospitalizations or surgeries and dates _____
_____
List serious injuries or accidents resulting in severe sprains, whiplash, fractures, dislocations, etc. _____
_____
List your primary care physician or any additional specialists visited in the last year:

Doctor	Reason	Approximate Date

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 _____

Terms of Acceptance

Moore Chiropractic is a cash practice. This means that you will be required to pay for your services at the time that they are rendered. We DO NOT accept insurance assignment, but we will file your insurance claim or provide you with the necessary information to file your claim (dependent upon your insurance provider). Any financial reimbursement from your insurance company will be mailed directly to you. Any exceptions to this policy must be discussed and agreed upon before beginning care. If we encounter any non-chiropractic findings during our examination, we will recommend that you seek the advice and services of a health care provider that specializes in that area. Our primary practice is the removal of nerve interference for restoration of health.

I have read and fully understand the above statements and accept chiropractic care on this basis. I agree to allow my treating chiropractor to use the methods and techniques that he feels are best for achieving optimal improvement for my condition.

Additionally, I acknowledge that I have received, reviewed, and understand to the Notice of Privacy Practices of Moore Chiropractic (AKA Kent Moore Chiropractic P.A.) which describes the clinic's policies and procedures regarding the use and disclosure of any protected health information received, created, or maintained by the clinic.

Signature _____ Date _____

MOORECHIROPRACTIC
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