Moore Chiropractic

NEW PATIENT INTAKE FORM

CONFIDENTIAL PATIENT INFORMATION

Last Name_____ First _____ M.I. ___ Nick Name _____

Address_____ City, State, Zip _____

Home Phone_____ Work _____ Cell _____ E-mail _____

Would you like to receive ❒ Text (Cell carrier _____) or ❒ E-mail reminders about upcoming appointments? ❒ No

Sex: ❒Female ❒ Male Ages of Children _____ Who may we thank for referring you to us? _____

Status: ❒ Minor ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Other _____

Date of Birth _____ Height _____ Weight _____

Occupation _____ Employer _____

Work Address _____ City, State, Zip _____

Spouse/ Parent's Name_____ Spouse/Parent Date of Birth _____

Emergency Contact _____Relationship_____ Phone _____

Language Preference ❒ English ❒ Spanish ❒ Mandarin ❒ Other: _____

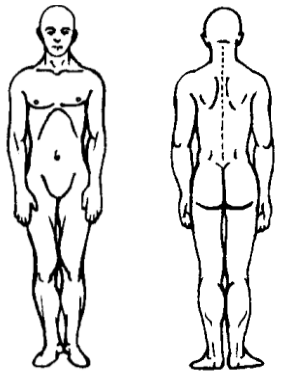
Interpretive services: Some health insurance plans provide interpretive services at no cost for patients, if needed.

If available, ❒Yes, I am requesting interpretive services for language(s) _____❒ No, I do not require interpretive services

Are you here for a free consultation only? ❒ Yes ❒ No

Today I will be paying by: ❒ Cash ❒ Credit Card ❒ Check

Please indicate where you are experiencing pain or discomfort by marking "X" on the diagram.



DESCRIBE YOUR CURRENT PROBLEM:

❒Headache ❒Neck Pain ❒Mid Back Pain ❒Lower Back Pain

❒Other _____

_____

Have you received care for this problem before? ❒ No ❒ Yes If yes, please explain:

_____

When did the condition(s) first begin? _____

How did the problem start: ❒ Suddenly ❒ Gradually ❒ Post-Injury ❒ Other _____

Is this condition ❒ Work Related ❒ Auto accident related? ❒ N/A

Is this condition: ❒ Getting Worse ❒ Improving ❒ Same

How often are your symptoms present? ❒ Occasional (0-25%) ❒ Intermittent (26-50%) ❒ Frequent (51-75%) ❒ Constant (76-100%)

What makes the problem better?_____

Please describe any activities that make problem worse or are restricted due to this/these complaints (i.e., washing dishes, walking, etc.)_____

_____

Current Complaint (how you feel today)

_____

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities, or household chores)?

_____

0 1 2 3 4 5 6 7 8 9 10

No interference Unable to carry on any activities

HEALTH HISTORY

In general, would you say your overall health right now is: ❒Excellent ❒Very Good ❒Good ❒Fair ❒Poor

Primary Care Physician Name _____ PCP Phone _____

Have you ever been diagnosed with: ❒Cancer ❒ Diabetes ❒ Stroke ❒Arthritis ❒ Scoliosis ❒ Osteoporosis ❒ Heart Disease

Other: _____ ❒ None

❒Alcohol/Drug Dependence	❒Prostate Problems	❒Menstrual Problems
❒Recent Fever	❒Urinary Problems	❒Taking Birth Control Pills
❒Diabetes	❒Marked Morning Pain/Stiffness	❒Visual Disturbances
❒High Blood Pressure	❒Osteoporosis	❒Dizziness/Fainting
❒Stroke (Date) _____	❒Pain at Night	❒Numbness in Groin/Buttocks
❒Corticosteroid Use (Cortisone, Prednisone, etc.)	❒Pain Unrelieved by Position or Rest	❒Epilepsy/Seizures
❒Abnormal Weight ❒Gain ❒Loss	❒Tobacco Use – Type_____Frequency _____/Day	
❒Cancer/Tumor (Explain) _____	❒Other Health Problems (Explain) _____	

Please list all medications you are currently taking: _____ ❒ None

Please list all past surgeries with dates: _____ ❒ None

Women: Is there a possibility that you may be pregnant? ❒ No ❒ Yes #Weeks _____

FAMILY HEALTH HISTORY Do you have a FAMILY history of: ❒Cancer ❒ Diabetes ❒ High Blood Pressure ❒ Stroke

❒Rheumatoid Arthritis ❒ Scoliosis ❒ Osteoporosis ❒ Heart Disease Other: _____ ❒ None

CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ❒ Resolve existing condition(s) ❒ Overall wellness

Have you ever visited a chiropractor? ❒ Yes ❒ No If yes, what is their name? _____Last visit: _____

Have you had x-rays before? ❒ No ❒ Yes, When? _____ What areas? _____

List past MRI or CT scans with dates, what areas, and where scan was performed:_____

TRAUMAS: PHYSICAL INJURY HISTORY

Have you ever had any significant falls or other injuries as an adult? ❒ Yes ❒ No

If yes, explain _____

Notable childhood injuries? ❒ Yes ❒ No If yes, please explain: _____

Youth or college sports? ❒ Yes ❒ No If yes, please explain: _____

Any auto accidents? ❒ Yes ❒ No If yes, please list dates and explain: _____

Work related injuries? ❒ Yes ❒ No If yes, please list dates and explain: _____

Exercise Frequency: ❒ None ❒ 1-2x per week ❒ 3-5x per week ❒ Daily Types of exercise: _____

How do you normally sleep? ❒ Back ❒ Side ❒ Stomach Do you wake up: ❒ Refreshed and Ready ❒ Stiff and Tired

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone? _____

Do you have any health concerns for other family members today? _____

YOUR HEALTH GOALS (List your top three health goals):

1) _____
2) _____
3) _____

I certify to the best of my knowledge the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this office, I understand that I am liable for all charges for services rendered and I agree to notify this office immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to my chiropractor to contact my physician, if necessary.

Name _____**Patient/Guardian Signature** _____ **Date:** _____