Patient History Form

Moliver Chiropractic

Patient Name _____ Date of Birth _____ /_____ / _____

Home Address _____ Age _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Social Security Number _____ ☐ Male ☐ Female Marital Status _____

Race (circle one) American Indian / Asian / Alaska Native / White / Black or African American / Native Hawaiian / Other Pacific Islander / Declined to state

Ethnicity (circle one) Hispanic or Latino / Not Hispanic or Latino / Declined to state Preferred Language _____

Employer _____ Job Description _____

Name of Spouse _____ Number of Children _____

Emergency Contact Name _____

Relationship _____ Phone Number _____

How did you hear about our office? _____

Who is responsible for payment? ☐ Self ☐ Spouse ☐ Health Ins. ☐ Medicare ☐ Medicaid ☐ Auto ☐ workers comp

What is the reason for this appointment? _____

Date symptoms began _____/_____/_____ Problem due to: ☐ Injury ☐ Work related ☐ Long- term problem

Is this related to an accident? ☐ Yes ☐ No Date of Accident _____/_____/_____

How did the accident occur? _____

Have you seen other doctors for this condition? ☐ Yes ☐ No

If yes, who? (Name) _____ Type of treatment _____

Have you been treated by a doctor or health care professional in the last year? ☐ Yes ☐ No

If yes, for what conditions? _____

Have you ever been under Chiropractic Care before? ☐ Yes ☐ No When? _____ Where? _____

PLEASE CHECK THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH/WELL-BEING

_____ I am only concerned about relief of a particular symptom.

_____ I am only concerned about relief of a particular symptom and preventing it's return.

_____ I want optimum health and well-being on every level available to me.

Insurance Information

Name of Insurance _____ Address _____

Policy # _____ Group # _____ Phone # _____

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examination, x-ray studies, Chiropractic care or any other services that he/she deems necessary in my case: and I further authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the services rendered to me including and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds or employers.

Patient's Signature _____ Date _____

Signature of Parent or Guardian _____ Date _____

over →

REVIEW OF SYSTEMS:
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body!

Health Questionnaire

Please check each of the conditions below that you are currently experiencing, circle NONE if none apply:

Cardiovascular	Past	Present
NONE		
Poor circulation	☐	☐
Hypertension	☐	☐
Aortic aneurism	☐	☐
Heart disease	☐	☐
Heart attack	☐	☐
Chest pain	☐	☐
High cholesterol	☐	☐
Pace maker	☐	☐
Jaw pain	☐	☐
Irregular heartbeat	☐	☐
Swelling of legs	☐	☐

Genitourinary		
NONE		
Kidney disease	☐	☐
Burning urination	☐	☐
Frequent urination	☐	☐
Blood in urine	☐	☐
Kidney stones	☐	☐
Lower side pain	☐	☐

Neurologic		
NONE		
Stroke	☐	☐
Seizures	☐	☐
Head injury	☐	☐
Brain aneurysm	☐	☐
Numbness	☐	☐
Severe headaches	☐	☐
Pinched nerves	☐	☐
Parkinson's	☐	☐
Carpal tunnel	☐	☐
Vertigo	☐	☐

ARE YOU PREGNANT?
☐ Yes ☐ No

Respiratory	Past	Present
NONE		
Asthma	☐	☐
Tuberculosis	☐	☐
Short of breath	☐	☐
Emphysema	☐	☐
Cold/flu	☐	☐
Cough	☐	☐
Wheezing	☐	☐

Endocrine		
NONE		
Thyroid	☐	☐
Diabetes	☐	☐
Hair loss	☐	☐
Menopausal	☐	☐
Menstrual	☐	☐

Hematologic		
NONE		
Hepatitis	☐	☐
Blood clots	☐	☐
Cancer	☐	☐
Bruising	☐	☐
Bleeding	☐	☐
Fever, chills	☐	☐
Sweating	☐	☐

Gastrointestinal		
NONE		
Gall bladder problems	☐	☐
Bowel problems	☐	☐
Constipation	☐	☐
Liver problems	☐	☐
Ulcers	☐	☐
Diarrhea	☐	☐
Nausea/vomiting	☐	☐
Bloody stools	☐	☐
Poor appetite	☐	☐

Eyes	Past	Present
NONE		
Glaucoma	☐	☐
Double vision	☐	☐
Blurred vision	☐	☐

Ear, Nose and Throat		
NONE		
Difficulty swallowing	☐	☐
Dizziness	☐	☐
Hearing loss	☐	☐
Sore throat	☐	☐
Nosebleeds	☐	☐
Bleeding gums	☐	☐
Sinus infection	☐	☐

Musculoskeletal		
NONE		
Gout	☐	☐
Arthritis	☐	☐
Joint stiffness	☐	☐
Muscle weakness	☐	☐
Osteoporosis	☐	☐
Broken bones	☐	☐
Joints replaced	☐	☐

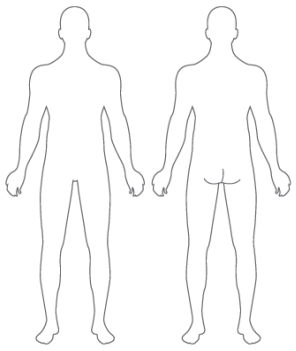
Allergic/Immunologic	Past	Present
NONE		
Hives	☐	☐
Immune disorder	☐	☐
HIV/AIDS	☐	☐
Allergy shots	☐	☐
Food allergies	☐	☐

Medication ☐ Yes ☐ No
Which medications? _____
_____
_____
_____

Psychiatric		
NONE		
Depression	☐	☐
Anxiety	☐	☐
Stress	☐	☐

Constitutional		
NONE		
Weight loss/gain	☐	☐
Low energy level	☐	☐
Difficulty sleeping	☐	☐

Locations (where does it hurt?)



P - Pain
N - Numb
S - Spasm
T - Tender
B - Burning
R - Radiating

Intensity of current symptom
Least 1 2 3 4 5 6 7 8 9 10 Worst

When is it worst? ☐ **Morning** ☐ **Afternoon** ☐ **Night**

Social History

Caffeine use	☐ occasional	☐ often	☐ never
Alcohol use	☐ occasional	☐ often	☐ never
Chewing tobacco	☐ occasional	☐ often	☐ never
Exercise	☐ occasional	☐ often	☐ never

Smoking status ☐ never ☐ former smoker
☐ current everyday smoker ☐ current some day smoker
Smoking start date _____ end date _____

Family History (check all that apply)

Arthritis	☐ Mother	☐ Father	☐ Brother	☐ Sister
Cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister
Diabetes	☐ Mother	☐ Father	☐ Brother	☐ Sister
Heart disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
Hypertension	☐ Mother	☐ Father	☐ Brother	☐ Sister
Stroke	☐ Mother	☐ Father	☐ Brother	☐ Sister
Thyroid	☐ Mother	☐ Father	☐ Brother	☐ Sister

Other _____

Please list medications and/or vitamins you are currently taking:

_____ _____ _____

_____ _____ _____

Surgeries—please list all surgeries and dates

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____