CONFIDENTIAL HEALTH INFORMATION

All information you supply is kept confidential.

Please print clearly

Moore Family Chiropractic
90 Rockland Street
Hanover, MA 02339
781-826-5555

_____/_____/____ **Today's Date**

_____ **Whom may we thank for referring you?**

Gender ○ Male ○ Female

_____ **Your Legal Name**

_____/_____/_____ **Birth Date**

_____ **Social Security Number**

_____ **Your Address** **City** **State** **Zip**

_____ **Home Phone #**

_____ **Email Address**

_____ **Cell Phone #**

_____ **Employer**

_____ **Occupation**

_____ **Work Phone #**

_____ **Employer Address** **City** **State** **Zip**

May we contact you at work?
○ Yes ○ No

_____ **Emergency Contact**

_____ **Emergency Contact #**

Marital Status
Single ○ Married ○ Divorced ○
Separated ○ Widowed ○

_____ **Primary Care Physician**

_____ **PCP's Location**

FIRST COMPLAINT: _____

Onset (when did you first notice your current symptoms): _____

My symptoms are a result of: ○ Auto Injury ○ Work Injury Other**:** _____

Aggravating/Relieving Factors

What tends to worsen the problem?_____

What tends to lessen the problem? _____

Quality of your Symptoms (What does it feel like?)

○ Dull ○ Aching ○ Stiffness ○ Cramps ○ Shooting ○ Throbbing
○ Burning ○ Stabbing ○ Sharp ○ Numbness ○ Tingling Other: _____

Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

_____

Intensity (How bad is your pain?) **0----------5----------10**
Absent Uncomfortable Agonizing

Duration & Timing (How often do you experience the symptoms?)

○ Constant 100% ○ Frequent 75% ○ Intermittent 50% ○ Occasional 25% ○ Rare 10%

Prior Interventions (What have you done to relieve the symptoms?)

○ Over the counter drugs ○ Prescription drugs ○ Physical Therapy ○ Surgery ○ Acupuncture ○ Massage ○ Chiropractic

Patient's Name: _____ DOB: _____ Today's Date: ___/____/___

2nd COMPLAINT: _____

Onset (when did you first notice your current symptoms): _____

My symptoms are a result of: ○ Auto Injury ○ Work Injury Other**:** _____

Aggravating/Relieving Factors

What tends to worsen the problem?_____

What tends to lessen the problem? _____

Quality of your Symptoms (What does it feel like?)

○ Dull ○ Aching ○ Stiffness ○ Cramps ○ Shooting ○ Throbbing

○ Burning ○ Stabbing ○ Sharp ○ Numbness ○ Tingling Other: _____

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Activities of Daily Living

How does this condition currently interfere with your life & ability to function

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Rising out of a chair	○	○	○	○
Lying Down	○	○	○	○
Bending Over	○	○	○	○
Climbing Stairs	○	○	○	○
Using a computer	○	○	○	○
Driving	○	○	○	○
Getting in/out of a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery Shopping	○	○	○	○
Household Chores	○	○	○	○
Lifting	○	○	○	○
Reaching Overhead	○	○	○	○
Showering/Bathing	○	○	○	○
Dressing Myself	○	○	○	○
Love Life	○	○	○	○
Getting to Sleep	○	○	○	○
Staying Asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard Work	○	○	○	○

Patient Name: _____ DOB: ____/_____/_____ Today's Date: ____/____/____

Review of Systems

check any of the following that you have or have had

Musculoskeletal

- ○ Scoliosis
- ○ Knee/Ankle Injuries
- ○ Osteoporosis
- ○ TMJ Issues
- ○ Shoulder/Elbow/Wrist Injury
- ○ Headaches
- ○ Dizziness
- ○ None

Cardiovascular

- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Poor Circulation
- ○ Angina (Chest pain)
- ○ Excessive Bruising
- ○ Heart Disease
- ○ Stroke
- ○ None

Respiratory

- ○ Asthma
- ○ Apnea
- ○ Emphysema
- ○ Shortness of Breath
- ○ Pneumonia
- ○ Other _____
- ○ None

Infections

- ○ Whooping Cough
- ○ Tuberculosis
- ○ Chicken Pox
- ○ Mumps
- ○ Measles
- ○ Other: _____
- ○ None

Neurological

- ○ Anxiety
- ○ Depression
- ○ Headache
- ○ Dizziness
- ○ Pins & Needles
- ○ Numbness
- ○ None

Digestive

- ○ Anorexia/Bulimia
- ○ Ulcer
- ○ Food Sensitivities
- ○ Heartburn
- ○ Constipation
- ○ Diarrhea
- ○ None

Sensory

- ○ Blurred vision
- ○ Ringing in the ears
- ○ Hearing Loss
- ○ Chronic ear infections
- ○ Loss of smell
- ○ Loss of taste
- ○ None

Injuries

- ○ A fractured or broken bone
- ○ A spine or nerve disorder
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ None

Past Personal & Social History

Please check the following that you have HAD in the past or HAVE now.

Had	Have	
○	○	AIDS
○	○	Allergies
○	○	Cancer
○	○	Diabetes
○	○	Epilepsy
○	○	Glaucoma
○	○	Gout
○	○	Hepatitis
○	○	HIV positive
○	○	Malaria
○	○	Multiple Sclerosis

Operations

Surgical interventions that may or may not have included hospitalization

- ○ Appendix Removal
- ○ Bypass Surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine_____

_____

_____

Treatments

Check the ones you have used in the **past** or are **currently** using

Past	Currently	
○	○	Chiropractic Care
○	○	Acupuncture
○	○	Massage Therapy
○	○	Physical Therapy
○	○	Nutritional Supplements
○	○	Herbs
○	○	Homeopathy
○	○	Inhaler
○	○	Chemotherapy
○	○	Dialysis

Social History

Please let us know about your health habits

Alcohol Use	○ Daily	○ Weekly	How much? _____
Coffee Use	○ Daily	○ Weekly	How much? _____
Exercising	○ Daily	○ Weekly	How much? _____
Pain Relievers	○ Daily	○ Weekly	How much? _____
Soft Drinks	○ Daily	○ Weekly	How much? _____

Daily Water Intake _____

Hours of sleep/night _____

Hobbies _____

Patient Name: _____ DOB: ____/_____/_____ Today's Date: ____/____/____

Acknowledgments

To set clear expectations, improve communications and help you get the best results in the shortest time, please read each statement & initial your agreement

Initials _____ **I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence & designed to reduce or correct vertebral subluxations (spinal misalignments) Chiropractic is a separate & distinct healing art from medicine & does not proclaim to cure any named disease or entity.**

Initials _____ **I may request a copy of the Privacy Policy & understand how is describes how my personal health information is protected & released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I realize that an X-Ray examination may be hazardous to an unborn child & I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period ___/___/___.**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information as an extension of my care in this office.**

Initials _____ **I acknowledge that my insurance is an agreement between the carrier & me. I understand that I am financially responsible for the payment of any co-payments, co-insurance, deductibles or other non-covered services I receive. I understand that some services may be rejected by my insurance company & I will be fully responsible for the payment of these services.**

Initials _____ **To the best of my ability, the information I have supplied is complete & truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the Patient is a minor, print child's full name: _____

_____ _____/_____/_____

Signature