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, check NONE if none apply:

Constitutional ☐ NONE

	Past	Present
Chills	☐	☐
Drowsiness	☐	☐
Fainting	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Night sweats	☐	☐
Weakness	☐	☐
Weight gain	☐	☐
Weight Loss	☐	☐

Eyes ☐ NONE

	Past	Present
Blindness	☐	☐
Blurred vision	☐	☐
Cataracts	☐	☐
Change in vision	☐	☐
Double vision	☐	☐
Dry eyes	☐	☐
Eye pain	☐	☐
Field cuts	☐	☐
Glaucoma	☐	☐
Sensitivity to light	☐	☐
Tearing	☐	☐
Wear glasses	☐	☐

Cardiovascular ☐ NONE

	Past	Present
Angina	☐	☐
Chest pain	☐	☐
Claudication	☐	☐
Heart murmur	☐	☐
Heart problems	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Orthopnea	☐	☐
Palpitations	☐	☐
Shortness of breath	☐	☐
Swelling of legs	☐	☐
Vericose veins	☐	☐

Respiratory ☐ NONE

	Past	Present
Asthma	☐	☐
Bronchitis	☐	☐
Dry cough	☐	☐
Porductive cough	☐	☐
Coughing up blood	☐	☐
Difficulty breathing	☐	☐
Difficulty sleeping	☐	☐
Hemoptysis	☐	☐
Pneumonia	☐	☐
Sputum production	☐	☐
Wheezing	☐	☐

Muscuoloskeletal ☐ NONE

	Past	Present
Arthritis	☐	☐
Neck pain	☐	☐
Decreased motion	☐	☐
Gout	☐	☐
Injuries	☐	☐
Joint pain	☐	☐
Joint stiffness	☐	☐
Locking joints	☐	☐
Back pain	☐	☐
Muscle cramps	☐	☐
Muscle pain	☐	☐
Muscle twitching	☐	☐
Muscle weakness	☐	☐
Swelling	☐	☐

Integumentary ☐ NONE

	Past	Present
Breast lumps / pain	☐	☐
Change in nail texture	☐	☐
Change in skin color	☐	☐
Eczema	☐	☐
Hair growth	☐	☐
Hair loss	☐	☐
Skin disorders	☐	☐
Hives	☐	☐
Itching	☐	☐
Paresthesia	☐	☐
Rash	☐	☐
Skin lesions	☐	☐

Gastrointestinal ☐ NONE

	Past	Present
Abdominal pain	☐	☐
Belching	☐	☐
Black, tarry stools	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Heartburn	☐	☐
Hemorrhoids	☐	☐
Indigestion	☐	☐
Jaundice	☐	☐
Nausea	☐	☐
Rectal bleeding	☐	☐
Abnormal stool caliber	☐	☐
Abnormal stool color	☐	☐
Abnormal stool consistency	☐	☐
Vomiting	☐	☐
Vomiting blood	☐	☐

ENMT ☐ NONE

	Past	Present
Bad breath	☐	☐
Dentures	☐	☐
Deviated septum	☐	☐
Difficulty swallowing	☐	☐
Discharge	☐	☐
Dry mouth	☐	☐
Ear drainage	☐	☐
Ear pain	☐	☐
Frequent sore throats	☐	☐
Head injury	☐	☐
Hearing loss	☐	☐
Hoarseness	☐	☐
Loss of smell	☐	☐
Loss of taste	☐	☐
Nasal congestion	☐	☐
Nose bleeds	☐	☐
Post nasal drip	☐	☐
Sinus infections	☐	☐
Runny nose	☐	☐
Snoring	☐	☐
Sore throat	☐	☐
Ringing in ears	☐	☐
TMJ problems	☐	☐
Ulcers	☐	☐

Genitourinary ☐ NONE

	Past	Present
Birth control therapy	☐	☐
Burning urination	☐	☐
Cramps	☐	☐
Erectile dysfunction	☐	☐
Frequent urination	☐	☐
Hesitancy / dribbling	☐	☐
Hormone therapy	☐	☐
Irregular menstruation	☐	☐
Lack of bladder control	☐	☐
Prostate problems	☐	☐
Urine retention	☐	☐
Vaginal bleeding	☐	☐
Vaginal discharge	☐	☐

ARE YOU PREGNANT?

☐ Yes ☐ No

Neurological ☐ NONE

	Past	Present
Change in concentration	☐	☐
Change in memory	☐	☐
Dizziness	☐	☐
Headache	☐	☐
Imbalance	☐	☐
Loss of consciousness	☐	☐
Loss of memory	☐	☐
Numbness	☐	☐
Seizures	☐	☐
Sleep disturbance	☐	☐
Slurred speech	☐	☐
Stress	☐	☐
Strokes	☐	☐
Tremors	☐	☐

Psychiatric ☐ NONE

	Past	Present
Agitation	☐	☐
Anxiety	☐	☐
Appetite changes	☐	☐
Behavioral changes	☐	☐
Bipolar disorder	☐	☐
Confusion	☐	☐
Convulsions	☐	☐
Depression	☐	☐
Homicidal indication	☐	☐
Insomnia	☐	☐
Location disorientation	☐	☐
Memory loss	☐	☐
Substance abuse	☐	☐
Suicidal indication	☐	☐

Endocrine ☐ NONE

	Past	Present
Cold intolerance	☐	☐
Diabetes	☐	☐
Excessive appetite	☐	☐
Excessive hunger	☐	☐
Excessive thirst	☐	☐
Goiter	☐	☐
Hair loss	☐	☐
Heat intolerance	☐	☐
Unusual hair growth	☐	☐
Voice changes	☐	☐

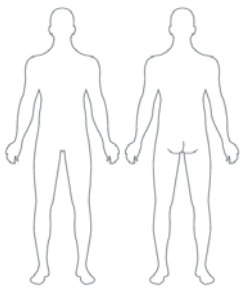
Allergic / Immunologic ☐ NONE

	Past	Present
History of Anaphylaxis	☐	☐
Itchy eyes	☐	☐
Sneezing	☐	☐
Specific food intoloerance	☐	☐
Medications	☐	☐

Hematologic / Lymphatic ☐ NONE

	Past	Present
Anemia	☐	☐
Bleeding	☐	☐
Blood clotting	☐	☐
Blood transfusions	☐	☐
Bruise easily	☐	☐
Lymph node swelling	☐	☐

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:

Name	Dosage / Start date	Name	Dosage / Start date	Name	Dosage / Start date
Name	Dosage / Start date	Name	Dosage / Start date	Name	Dosage / Start date

Surgeries—please list all surgeries and dates (include right or left when applicable)

1. R / L _____ _____
2. R / L _____ _____
3. R / L _____ _____
4. R / L _____ _____