Moore Chiropractic Clinic Case History

Date:_____ Patient File #_____-_____ Legacy File # _____

Name:_____ Cell: _____

Address:_____City:_____ State:_____ Zip:_____

Sex: ☐ Male. ☐ Female ☐ Other E-mail address:_____ Home/Alternate Phone:_____

Age:_____ Birth Date:_____ Social Security #_____ Marital Status: ☐ Married ☐ Single ☐ Other

Occupation:_____ Employer:_____

Name of Nearest Relative or Emergency Contact:_____ Phone:_____ Relationship _____

Your Primary Doctor or Nurse Practitioner, City, State Phone _____

May we update your Primary Care Provider about your care? ☐ Yes ☐ No

What is your communication Preference? ☐ Text ☐ Cell Phone Call ☐ Home Phone Call ☐ Friends Cell ☐ Family Member Cell

How did you find us? Name _____ ☐ Patient ☐ Signs ☐ FaceBook Ad ☐ Google ☐ Newspaper ☐ Radio ☐ Staff

HISTORY OF PRESENT ILLNESS:

Main Complaint: Purpose for this appointment:_____

Date symptoms appeared or accident happened:_____

Is this due to: ☐ Auto Accident ☐ Work Accident ☐ Personal Injury ☐ Other_____

Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe:_____

Days lost from work:_____ Date of last physical examination:_____ Date of last Chiropractic Adjustment _____

HISTORY

Have you ever been diagnosed as having or have suffered from?

PAST MEDICAL HISTORY

☐ Pace Maker
☐ Strokes
☐ Cancer
☐ Diabetes
☐ Sudden Weight Change

FAMILY HISTORY

___ Scoliosis (737.30)
___ Cancer

What are You Taking Meds for:

_____
_____
_____

SURGERIES	YEAR

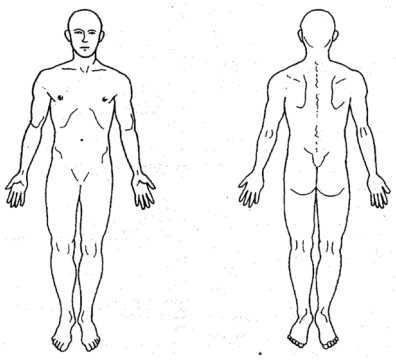
HOSPITALIZATIONS	YEAR

CAR ACCIDENTS	YEAR

SOCIAL HISTORY

Do you smoke? ☐ Never ☐ No ☐ Yes, Current ___Packs/day, for ___yrs Former Smoke quit?_____)

MARK YOUR AREAS OF CONCERN



INFORMED CONSENT TO TREAT: I understand and am informed that, in the practice of chiropractic medicine there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that I may revoke this consent at anytime verbally or in writing to the doctor. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the procedures outlined by my doctor of chiropractic in my treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

PRIVACY NOTICE: The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Parent or Guardian's Signature Authorizing Care:_____ Date:_____