HEALTH HISTORY

Name		Phone	
Address		City	Zip
Birthdate	Age	SSN	
Occupation		Work Phone	
Email		Preferred Contact	
Emergency Contact		Phone	Marital Status
Purpose of Visit			
When did this begin?			
What makes it worse?			
What makes it better?			
Describe how it feels			
Constant (100%)	Frequent (75%)	Intermittent (50%)	Occasional (25%)
How long does it last?			
List medications			
Other doctors			
Previous chiropractor(s)			Technique:
List all surgeries & dates			
Medical complications			
Injuries/Accidents			
Hobbies & activities			
Height	Weight		
Health Goals			
Dietary Restrictions			

Additional Notes:

HEALTH HISTORY

Please Check Accompanying Box If Relevant To Your Health History

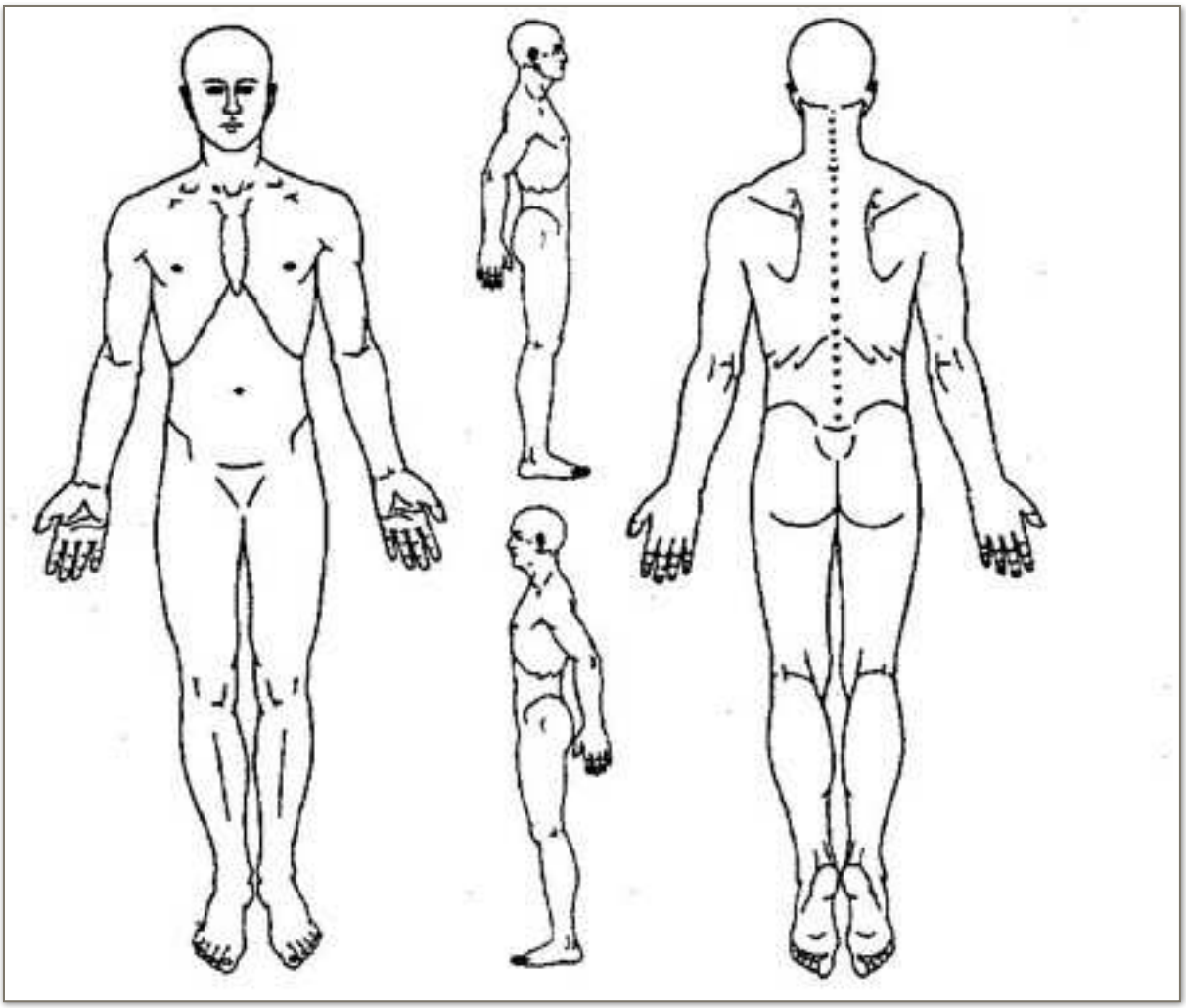
General	Neurological	Musculoskeletal	Doctors Notes
☐ Weight Loss/Gain ☐ Fatigue ☐ Insomnia ☐ Fever/Chills ☐ Trauma ☐ Diabetes ☐ Fainting ☐ Severe Allergy ☐ Cancer ☐ Fibromyalgia ☐ Depression ☐ Nervous/Anxiety ☐ Varicose Veins	☐ Dizziness ☐ Seizures ☐ Weakness ☐ Tingling/ Numbness ☐ Migraine Headaches ☐ Common Headache ☐ Multiple Sclerosis ☐ Concussion	☐ Neck/Back Pain ☐ Stiff Neck ☐ Joint Pain/ Stiffness ☐ Hip/Knee/Ankle Pain ☐ Shoulder/Elbow/ Wrist Pain ☐ Joint Swelling ☐ Scoliosis ☐ Plantar Fascitis ☐ Carpal Tunnel ☐ Arthritis ☐ Osteoporosis	
EENT	**Cardiovascular**	**Gastrointestinal**	
☐ Visual Changes ☐ Sinus Problems ☐ Hearing Loss ☐ Ringing in Ears ☐ TMJ/ Jaw ☐ Difficulty Chewing/ Swallowing	☐ High/Low Blood Pressure ☐ Chest Pain ☐ Shortness of Breath ☐ Palpitations ☐ Heart Disease ☐ Cold Hands/Feet ☐ Blood Clots ☐ Hemophilia	☐ Irritable Bowel Syndrome/IBS ☐ Abdominal Pain ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Indigestion ☐ Food Intolerance ☐ Crohn's Disease/ Colitis ☐ Gas	
Skin	**Respiratory**	**Other**	
☐ Rashes ☐ Lumps ☐ Itching ☐ Dryness ☐ Colour Changes ☐ Hair/Nail Changes ☐ New/Changes in mole	☐ Chronic Cough ☐ Asthma/Wheezing ☐ COPD/ Emphysema ☐ Tuberculosis	☐ Pregnant ☐ Nursing ☐ Menstrual Issues ☐ Infertility ☐ Sexual disorders ☐ Miscarriage	

HEALTH HISTORY

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins/Needles	Burning	Aching	Stabbing/Sharp
— — — — —	x x x x x x x	^ ^ ^ ^ ^ ^	o o o o o	# # # # # #
— — — — —	x x x x x x x	^ ^ ^ ^ ^ ^	o o o o o	# # # # # #



Doctors Notes:

INFORMED CONSENT

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgeably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I have read the above paragraph. I understand the information provided. The questions I have asked about this information have been answered to my satisfaction. Having this knowledge I knowingly authorize Dr Moore to proceed with chiropractic care and treatment.

Your Signature **Date** **Doctor's Signature**

***Parental Consent (only for Minor Patient under age 18)**:*

Patient Name: _____
Patient age: _____ DOB: _____

Printed name of person legally authorized to sign for

Patient: _____
Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for
Patient: _____
Signature: _____
Relationship to Patient: _____

Remarks:

HEALTH CARE AUTHORIZATION

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Dr Jason and Dr Melanie Moore to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

I give permission to Dr Moore to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.

If Dr Moore contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

I give permission to Dr Moore to use my name on a welcome board, referral board, and birthday board.

I give permission to Dr Moore to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.

I give permission to Dr Moore to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

I give Dr Moore permission to treat me in an open room when required, where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.

By signing this form you are giving Dr Moore permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care with Dr Jason and/or Dr Melanie Moore and will remain for an additional 7 years or until revoked by me with written notice.

RIGHT TO REVOKE AUTHORIZATION:
You have the right to revoke this authorization, in writing, at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice to the Privacy Official of Dr Jason and Dr Melanie Moore. The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this authorization;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

I have the right to refuse to sign this authorization. If I refuse to sign this authorization, Dr Moore will not refuse to provide treatment however, it will not be possible for Dr Moore to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since Dr Moore will be unable to contact me 3) all contact with Dr Moore regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/ disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

PLEASE FILL OUT YOUR INFORMATION BELOW

Patient's name (please print): _____

Patient's Signature: _____

Today's Date: _____

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print):

_____

*Signature:*_____

Description of Representative's Authority to Act on Patient's Behalf:

_____