PATIENT INFORMATION

Please print and answer the following questions as accurately and completely as possible.

Date:_____________ Would you like to receive text reminders for your appts? ▢ Yes ▢ No

Legal Name:____Age:____ Sex:____

Address:____

City:________________________ State:___ Zip:_______ Date of Birth:____/____/____

Phone Number:_______________________ email:______________________________

Employer:____________________________ Work Performed:______________________

Marital Status: M S W D Spouse's Name:____________________________________

Emergency Contact:___________________________ Phone Number:_______________

Family Physician:_______________________________ City:_______________ State:___

How did you hear about us?:____

Reason for today's visit:____

HEALTH HISTORY

Major Surgeries/Operations: ▢ Head ▢ Neck/Throat ▢ Chest/Heart/Lung ▢ Back

▢ Abdominal ▢ Other ____________________________

Previous Fractures or Broken Bones: ▢ Yes ▢ No What:_________________________

Previous Falls or Accidents: ▢ Yes ▢ No When:_________________________

Previous Hospitalization: ▢ Yes ▢ No Why:__________________________

Previous Chiropractic care: ▢ Yes ▢ No Doctor:________________________

Previous Spinal X-Rays/MRI/CT ▢ Yes ▢ No Where:________________________

Medications Currently Taking: ▢ Pain Killers/Muscle Relaxants ▢ Nerve/Antidepressant

▢ Blood Pressure ▢ Antibiotics ▢ Insulin/Other ▢ Stomach ▢ Heart ▢ Vitamins

Below are a list of diseases and disorders that may seem unrelated to the purpose of your appointment; however, the following information may affect your response to our care as well as our approach to handling your case. Please complete the following as thoroughly as possible.

▢ Allergies
▢ Diabetes
▢ Cancer
▢ Heart Problems
▢ Stroke
▢ Kidney Problems

▢ Osteo-Arthritis
▢ Epilepsy
▢ AIDS or ARC
▢ Frequent Illnesses
▢ Fibromyalgia
▢ Addictions Past/Present

▢ Rheumatoid Arthritis
▢ Gout
▢ Chronic Fatigue
▢ Lupus
▢ ALS/MS
▢ Parkinson's

Intake or Use:
▢ Alcohol
▢ Tobacco
▢ Caffeine
▢ Drugs

Do you exercise regularly? ▢ Yes ▢ No Are you dieting? ▢ Yes ▢ No Since____________

CHECK ANY PROBLEMS YOU HAVE HAD IN THE LAST YEAR

MUSCLES-SKELETON
▢ Low Back
▢ Middle Back
▢ Neck
▢ Arm(s)
▢ Leg(s)
▢ Shoulder(s)
▢ Knee(s)
▢ Jaw-TMJ
▢ General Stiffness

NERVOUS SYSTEM
▢ Headaches
▢ Nervousness
▢ Depression
▢ Numbness/Tingling
▢ Muscular Weakness
▢ Dizziness
▢ Fainting
▢ Seizures
▢ Stress
▢ Shaking/Tremors

CIRCULATION-BREATHING
▢ Chest
▢ Breathing
▢ Blood Pressure
▢ Heart
▢ Lungs
▢ Poor Circulation

DIGESTION-ELIMINATION
▢ Poor Appetite
▢ Excessive Thirst
▢ Nausea
▢ Diarrhea
▢ Constipation
▢ Hemorrhoids
▢ Weight Loss/Gain
▢ Gas/Bloating
▢ Heartburn

MALES ONLY
▢ Prostate problems
▢ Testicular problems
▢ Erectile dysfunction

EYE-EARS-NOSE-THROAT
▢ Eyes
▢ Dental
▢ Throat
▢ Ear(s)
▢ Nose
▢ Sinus

URINARY-GENITALS
▢ Pain upon urination
▢ Infrequent urination
▢ Frequent urination
▢ Weak urine stream
▢ Bladder control

FEMALES ONLY
▢ Menstrual problems
▢ Low back pain with periods
▢ Breast lumps/problems

Are you pregnant?
▢ Yes ▢ No ▢ Not Sure

FAMILY HEALTH HISTORY (i.e., heart, cancer, stroke, diabetes, blood pressure, etc.)

Mother's Side____

Father's Side:____

Signature of fact, Acknowledgement of Payment Policy and Receipt of Notice of Privacy Practices.

I understand that my care in this office may involve the making of judgements that are based upon the facts known by the doctor; therefore, the above information is true and complete to the best of my knowledge.

I understand and agree that any health or accident insurance policies that I have are an arrangement between the insurance company and myself and that Moving Toward Balance (MTB) is not a party to that contract. I acknowledge that MTB does not file insurance claims and that I am personally responsible for the payment of all services provided by MTB. **I understand that payment is due at the time services are rendered.** A receipt is available upon request.

I acknowledge that I have received, reviewed, understand, and agree to the Notice of MTB, which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

____ ____________________

Patient's/Parent's/Legal Guardian Signature **Date**