

MOORE CHIROPRACTIC Daniel L. Moore, D.C.
Route 1,6843 Main Street Bonners Ferry, Idaho 83805
Phone (208) 267-2506 Fax (208) 267-6080

Patient Information (Please Print)

TODAY'S DATE: _____

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name _____ S/S# _____ - _____ - _____ Age _____
First MI Last

Address _____ City _____ State _____ Zip _____

Sex: Female Male Birth Date: _____

Home phone #: _____ Work phone #: _____ Cell phone#: _____

Do you prefer to receive calls at: Home Work Either

Are you: Minor Married Divorced Widowed Single Separated

Your employer: _____ Occupation _____

Business Address _____ City- _____ State _____ Zip _____

Spouse's Name _____ Workplace _____ Work Phone # _____

Spouse's Birth Date _____ Spouse's Cell phone #- _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

Parent or Guardian (if you are a minor or student, please use your parent's information here.)

Name & Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of Employer _____ Work Phone # _____

Mother's Birth Date _____ Father's Birth Date _____

Symptoms

Reason for visit _____ When did you first notice the symptoms? _____

Is this condition getting progressively worse? _____ Better? _____ Staying the Same? _____

Where specifically is the problem(s) located? _____

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down Other

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition? Medication Surgery Physical Therapy

(7 Other _____

Health History

Check conditions which you have experienced ever:

- | | | | | |
|--|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tonsillitis |

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke | _____ |

Dates of last exams _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

List any types of surgeries which you have had and the dates which they occurred: Appendix Tonsils Hernia

Hemorrhoid Spinal Hysterectomy Prostate Cyst Cancer Other _____

List previous accidents/injuries/major illnesses/fractures/dislocations/concussions: _____

Please list all medications you are currently taking: _____

Allergies: _____

Is this visit due to an accident or injury? _____ If so, date of injury: _____ PLEASE NOTIFY FRONT DESK!

Name of Medical Doctor _____ Have you ever been under Chiropractic care? _____

If yes, please give doctor's name _____

Daily Habits

What type of exercise do you perform regularly? _____ Level? None Moderate Heavy

What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work) _____

What vitamins do you currently take? _____

What kind of other nutritional supplements do you take (if any)? _____

Do you smoke? No Yes How much per day? _____ How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

PLEASE READ THE FOLLOWING BEFORE SIGNING!

We invite you to discuss frankly with us any questions regarding our services. The best chiropractic service is based on a friendly mutual understanding between physician and patient.

Our office policy requires payment in full for all services rendered at the time of service. A finance charge of 1.5% per month, \$2.00 minimum on all accounts over 30 days will be charged. If the account is not paid within 90 days of the date of service, and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account. A charge may be incurred for missed appointments or appointments not cancelled within twenty-four hours.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform this office of any changes in my medical status. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature _____ Date _____

Health Survey

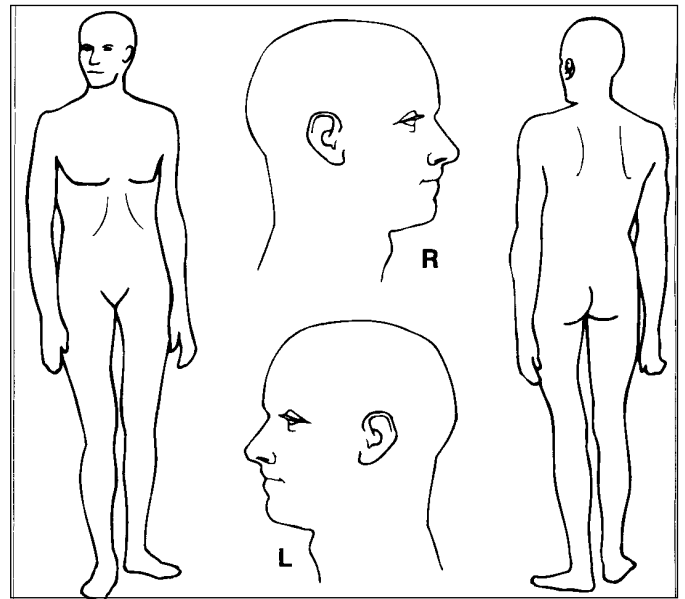
Please rate each condition below with one of the appropriate following symbols

X presently have ✓ previously had — never had.

- | | |
|--|--|
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Cardiovascular |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Pain over heart |
| <input type="checkbox"/> Difficult chewing | <input type="checkbox"/> Difficult breathing |
| <input type="checkbox"/> Difficult swallowing | <input type="checkbox"/> Persistent cough |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Coughing phlegm |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Vomiting food | <input type="checkbox"/> Rapid heartbeat |
| <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Blood pressure problems |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Black stool | <input type="checkbox"/> Eye, Ear, Nose and Throat |
| <input type="checkbox"/> Bloody stool | <input type="checkbox"/> Eye strain |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Eye inflammation |
| <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Ear pain |
| <input type="checkbox"/> Weight trouble | <input type="checkbox"/> Ear noises |
| <input type="checkbox"/> Nervous System | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Ear discharge |
| <input type="checkbox"/> Loss of feeling | <input type="checkbox"/> Nose pain |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Nose bleeding |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nose discharge |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficult breathing thru nose |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sore gums |
| <input type="checkbox"/> Muscle jerking | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Convulsion | <input type="checkbox"/> Sore mouth |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Difficult speech |

- | | |
|---|--|
| <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Genitourinary |
| <input type="checkbox"/> Low back problems | <input type="checkbox"/> Bladder trouble |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Excessive urination |
| <input type="checkbox"/> Neck problems | <input type="checkbox"/> Scanty urination |
| <input type="checkbox"/> Arm problems | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Leg problems | <input type="checkbox"/> Discolored urine |
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Female |
| <input type="checkbox"/> Painful joints | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Stiff joints | <input type="checkbox"/> Vaginal bleeding |
| <input type="checkbox"/> Sore muscles | <input type="checkbox"/> Vaginal pain |
| <input type="checkbox"/> Weak muscles | <input type="checkbox"/> Breast pain |
| <input type="checkbox"/> Walking problems | <input type="checkbox"/> Lumps on breasts |
| <input type="checkbox"/> Ruptures | Are you pregnant |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Mark areas of pain resulting from this accident on figures below



Patient's signature _____
 (If a minor, parent's or guardian's signature) _____ Date _____

Office Use (Do not write below here)

Doctor's signature _____ Date _____