MOTION LAB
CHIROPRACTIC

Confidential Health Information

Today's Date (MM/DD/YYYY)

Have you consulted a Chiropractor before?
O Yes O No When?_____

Whom may we thank for referring you?

Your Last Name **Your First Name** **Your Middle Initial**

Gender
O Male O Female

Birth Date (MM/DD/YYYY)

Marital Status
O Single O Married
O Divorced O Widowed
O Separated

Race: _____ **Ethnicity: O Non Hispanic/Latino**
O Hispanic/Latino

Height: __ft__in Weight: _____lbs

Home Address

City **State** **Zip Code** **Home Phone** **Spouse's Name**

E-mail Address **Cell Phone** **Children's Ages**

Emergency Contact **Your Occupation**

Your Employer **Employers Address**

May we contact you at work?
O Yes O No

City **State** **Zip Code**

Preferred method of contact?
O Home Phone O Cell Phone
O Work Phone O Email

Work Phone

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (check circle): O An accident or injury
O Work O Auto O Other _____
O A worsening long-term problem

O An interest in: O Wellness O Other

3. Onset (When did you first notice your symptoms?)

_____

4. Intensity: (How extreme are your current symptoms?)

O-O-O-O-O-O-O-O-O-O-O
0 1 2 3 4 5 6 7 8 9 10

0: No pain
10: Extreme Pain

5. Duration and Timing: (When did it start, and how often do you feel it?)

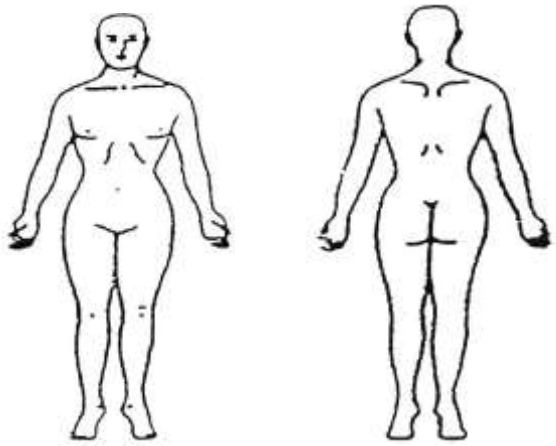
O Constant O Comes and goes

How Often? _____

6. Quality of Symptoms
(What does it feel like?)

O Numbness
O Tingling
O Stiffness
O Dull
O Aching
O Cramps
O Nagging
O Sharp
O Burning
O Shooting
O Throbbing
O Stabbing
O Other: _____

7. Location (Where does it hurt?) -X the areas of pain below



8. Radiation: (Does it affect other areas of your body**?** To what areas does the pain radiate, shoot or travel?)

_____

9. Aggravating/Relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc?)

-What tends to worsen the problem? _____
_____

- What tends to lessen the problem? _____
_____

10. Prior Interventions (What have you done to relieve symptoms?)

O Prescription Medicine O Surgery
O Over-the-counter drugs O Acupuncture
O Homeopathic remedies O Chiropractic
O Physical Therapy O Massage
O Ice O Heat
O Other: _____

12: How does your condition interfere with your:

Work or career: _____
Recreational activities: _____
Household Responsibilities: _____
Personal Relationships: _____

13. Review of Systems:
Chiropractic care focuses on the nervous system, which affects all areas of your health. Please X the circles to indicate whether you've HAD or currently HAVE any of the conditions/symptoms below.

Musculoskeletal:

Had	Have	
O	O	Osteoporosis
O	O	Arthritis
O	O	Scoliosis
O	O	Neck pain
O	O	Back problems
O	O	Hip disorders
O	O	Knee injuries
O	O	Foot/ankle pain
O	O	Shoulder problems
O	O	Elbow/wrist pain
O	O	TMJ issues
O	O	Poor posture

O - None

Neurological:

Had	Have	
O	O	Anxiety
O	O	Depression
O	O	Headache
O	O	Dizziness
O	O	Pins and needles
O	O	Numbness
O	O	Fatigue
O	O	Sudden weight gain/loss
O	O	Weakness
O	O	Poor appetite
O	O	Fainting

O - None

Cardiovascular:

Had	Have	
O	O	High blood pressure
O	O	Low blood pressure
O	O	High cholesterol
O	O	Poor circulation
O	O	Angina
O	O	Excessive bruising

O - None

Respiratory:

Had	Have	
O	O	Asthma
O	O	Apnea
O	O	Emphysema
O	O	Hay fever
O	O	Shortness of breath
O	O	Pneumonia

O - None

Digestive:

Had	Have	
O	O	Anorexia/Bulimia
O	O	Ulcer
O	O	Food sensitivities
O	O	Heartburn
O	O	Constipation
O	O	Diarrhea

O - None

Sensory:

Had	Have	
O	O	Blurred vision
O	O	Ringing in ears
O	O	Hearing loss
O	O	Chronic ear infections
O	O	Loss of smell/Loss of taste

O - None

Integumentary:

Had	Have	
O	O	Skin cancer
O	O	Psoriasis
O	O	Eczema
O	O	Acne
O	O	Hair loss
O	O	Rash

O - None

Endocrine:

Had	Have	
O	O	Thyroid issues
O	O	Immune disorders
O	O	Hypoglycemia
O	O	Frequent infections
O	O	Low energy

O - None

Genitourinary:

Had	Have	
O	O	Kidney Stones
O	O	Infertility
O	O	Bedwetting
O	O	Prostate issues
O	O	PMS symptoms

O - None

Past Personal, Family and Social History

Please identify your past health history, including ALL accidents, injuries and treatments.

14. Illnesses

Check the illnesses you may have HAD in the past, or currently HAVE now.

Had	Have	
O	O	AIDS
O	O	Alcoholism
O	O	Allergies
O	O	Arteriosclerosis
O	O	Cancer
O	O	Chicken pox
O	O	Diabetes
O	O	Epilepsy
O	O	Glaucoma
O	O	Goiter
O	O	Gout
O	O	Heart Disease
O	O	Hepatitis
O	O	HIV positive
O	O	Malaria
O	O	Measles
O	O	Multiple Sclerosis
O	O	Mumps
O	O	Polio
O	O	Rheumatic Fever
O	O	Scarlet Fever
O	O	Stroke
O	O	Tuberculosis
O	O	Typhoid Fever
O	O	Ulcer

Other: _____
_____
_____
_____

15. Injuries:

O Had a fractured or broken bone
O Had a spine or nerve disorder
O Been knocked unconscious
O Been injured in an accident
O Used a crutch or other support
O Used neck or back bracing

Are you currently a smoker?

O – YES O - NO

16. Operations:

Surgical interventions, which may or may not have included hospitalization.

O Appendix removal
O Bypass surgery
O Cancer
O Cosmetic surgery
O Elective surgery
O Eye surgery
O Hysterectomy
O Pacemaker
O Spine _____
_____
_____
O Tonsillectomy
O Other: _____
_____
_____

17. Treatments

Past	Currently	
O	O	Acupuncture
O	O	Antibiotics
O	O	Birth control pills
O	O	Blood transfusion
O	O	Chemotherapy
O	O	Chiropractic care
O	O	Dialysis
O	O	Herbs
O	O	Homeopathy
O	O	Hormone replacement
O	O	Inhaler
O	O	Massage therapy
O	O	Physical therapy
O	O	Nutritional supplements

List:_____
_____
_____

O O Medications
(prescription/over-the-counter)
List:_____
_____
_____

O O Allergies
List:_____
_____
_____

18. <u>Family History</u>:
Some health issues are hereditary. Please inform us about the health of your immediate family members.

Relative	**Age** (If living)	**State of health** (Circle one)	**Illnesses** – Please list	**Age at death**	**Cause of death** (Circle one)
Mother		Good/Poor			Natural/Illness
Father		Good/Poor			Natural/Illness
Sister 1		Good/Poor			Natural/Illness
Sister 2		Good/Poor			Natural/Illness
Brother 1		Good/Poor			Natural/Illness
Brother 2		Good/Poor			Natural/Illness

Are there any hereditary health issues that you know about?_____
_____

19. <u>Social History</u>:

Alcohol Use O Daily O Weekly How much?_____
Coffee Use O Daily O Weekly How much?_____
Tobacco Use O Daily O Weekly How much?_____
Exercising O Daily O Weekly How much?_____
Pain Relievers O Daily O Weekly How much?_____
Soft drinks O Daily O Weekly How much?_____
Water Intake O Daily O Weekly How much?_____
Hobbies?_____
Job pressure/stress? O – YES O – NO
Recreational drugs? O – YES O – NO

20. **How much sleep do you average per night? _____ Hours**
21. **What is the type and approximate age of your mattress/pillow? _____**
22. **What is your preferred sleep position? _____**
23. **Describe your typical eating habits: O Skip Breakfast**
    O Two meals/day
    O Three meals/day
    O Snacking between meals

Acknowledgements:
To set clear expectations, improve communications and help you get the best results in the shortest time, please read each statement and initial you agreement**.**

Initials ___ **I instruct the Chiropractor to deliver care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ___ **I may request a copy of the privacy policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ___ **I grant permission to be called to confirm or reschedule an appointment and to be send occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ___ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ___ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.**

Initials _ *****ATTENTION Medicare and Medicare Crossover patients: Per Medicare guidelines not all chiropractic services are covered. All non-covered services are due at time of service.***

If the patient is a minor child, print child's full name:_____

_____ _____
Signature **Date (MM/DD/YYYY)**