Moore Chiropractic Office Date: ________________________

PERSONAL DATA

Name ____ Age __________ Date of Birth _____________________
Both Parent's names (if you are under 18)____
Home Address __________________________________ City __________________ State ______ Zip _____________
Home phone (____) ___________________________ Business Phone (____) ___________________________________
Cell Phone (____) _________________________Carrier____________________ SS#___________________________
E-mail address____@ ____________________________________
Occupation _____________________________ Employer ____
Marital Status ❑S ❑M ❑D ❑W ❑L/W Spouse/Partners name ____
Names and Ages of Children____
Whom may we thank for referring you to our office? ____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Moore Chiropractic Office can address for you? ___________________________________
____

Are these concerns affecting your quality of life? (Please circle all that apply)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑ Y ❑ N Name of D.C. ____________________________________
How long under care? ❑ ______days ❑______weeks ❑ ______months ❑ ______ years
Date of last visit: ____________________Why did you stop care?____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

❑Medical Physician ❑Naturopath ❑Acupuncturist ❑Homeopath

❑Massage Therapist ❑Psychotherapist ❑Energy Healer ❑Dentist

Reason:____
____ __

FOR WOMAN Are you pregnant? Y N Date of last menstrual period: ____
If x-rays are recommended, your signature is required (below) to verify that you are **not pregnant.**

Signature: ____Date:___________________________________
If pregnant, Due Date: _____________ Name of OBGYN or Midwife____
Where will you be birthing your baby? ❑Hospital ❑Home ❑Birthing Center ❑Other_____________________

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body which coordinates health is the NERVE SYSTEM.
The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.
Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.
VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.
Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses you have been subjected to in your life, how they may relate to your present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please CHECK where and how you were birthed. (If you do not know, please skip to next question)

❑ Home ❑ Natural ❑ Hospital ❑ Caesarian section ❑ Forceps
❑ Breech ❑ Cord around neck ❑ Prolonged labor ❑ Drug induced labor ❑ Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list.
Please list the major traumas that you remember from your childhood up to the present.
Have you had any accidents due to any of the following? (Check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, state type of injury and date:

____

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? ❑ Y ❑ N

If yes, list body parts injured and dates of injuries:

____

Have you ever been hospitalized or had surgery? ❑ Y ❑ N

If yes, state reason and dates: ____

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N	Illness	Y	N

HEALTH, WELLNESS AND CHIROPRACTIC CARE

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? ❑ Y ❑ N If yes, did you have a reaction? ❑ Y ❑ N ❑Unsure

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy
❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list:____

Do you have allergies or sensitivities to any foods? ❑ Y ❑ N If yes, please list:

____

Do you presently consume any of the following?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter):____

____

____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE (presently)

How do you grade your physical health? ❑ Good ❑ Fair ❑ Poor
How do you grade your emotional/mental health? ❑ Good ❑ Fair ❑ Poor
How do you grade your overall "quality of life"? ❑ Good ❑ Fair ❑ Poor

Do you exercise regularly? If yes, how often? ____

Do you take supplements? If yes, please list: ____

Do you follow a special dietary regime? ____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

❑ Relief of a symptom or problem
❑ Relief and Prevention of a symptom or problem
❑ Healthier spine and nerve system
❑ Optimal health on all levels
❑ OTHER ____

Consent Form

1. I have been informed that a copy of Moore Chiropractic's "Notice of Privacy Practices for Protected Health Information (HIPAA)" brochure is available for my review both in the office Yes____ No____
2. I understand that most care is given in an open setting. Private rooms are available upon request
3. I consent to receive communication from WFC via email, postal mail, text and telephone messaging in connection with my care. Yes___ No___
   If I should withdraw my consent, I will notify the office in writing.
4. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. Yes___ No___

Our Unique Approach to Finances at Moore Chiropractic

Our patients pay for care "out of pocket" because insurance plans DO NOT COVER corrective or wellness care. For that reason, we utilize uniquely designed, discounted cash plans to allow you to receive all the care necessary at affordable fees. Our plans also allow **unlimited visits for a fixed fee**, similar to a health club. This gives our practice members the unique opportunity to maximize their results and regain and sustain their health and function without worrying about finances. These plans will be discussed with you on your second visit once we have determined your goals and the amount and type of care you need.

Insurance

Insurance coverage varies greatly. We cannot predict whether your policy will reimburse you for any of the services we provide in our office. It is your responsibility to contact your insurance company to determine the amount and extent of coverage. If you determine that your insurance will reimburse you for chiropractic care in our office, we will provide you **with itemized monthly statements** for **you** to submit.

If you have had an **Auto Accident, a Worker's Compensation Injury or a Personal Injury**:
Have you been treated for injuries? Yes___ No___ If yes, where? _______________________________
What services were provided? ____

Name: (Printed) ____Date: _________________________
Signature:____

Signature of Parent (for minor):____
Child's Name: (Printed) ____
Parent or Legal Guardian's Name: (Printed)____
Date:__________________________________

Welcome and thank you for choosing Moore Chiropractic Office!