Moore Chiropractic
Health Care Center
(512)459-5523

Dr. Michele K. Moore
8301 Shoal Creek Blvd.
Austin, TX 78757

# CONFIDENTIAL PATIENT HEALTH RECORD

## PERSONAL HISTORY

Full Name: _____ Home Address: _____
City: _____ State: _____ Zip: _____ E-mail Address: _____
Home Phone: (____)_____ Birth Date: _____ Age: _____ Sex: ☐M ☐ F
Cell Phone: _____ Social Security #: _____
Business Employer: _____ Business Phone: (____)_____ Type of Work: _____
Select: ○ Married ○ Single ○ Widowed ○ Divorced ○ Separated Name of Spouse: _____
Spouse's Employer: _____ Type of Work: _____
Names and Ages of Children: _____
Referred To This Office By: ☐Friend ☐Phonebook ☐Insurance ☐Website ☐Other: _____
Emergency Contact Name: _____ Phone: (____)_____ Relationship: _____

## INSURANCE INFORMATION

Who is responsible for your bill, you and: ☐Spouse ☐Auto ☐Insurance ☐Medicare ☐Other:_____
Personal Health Insurance (Name): _____ Health Insurance ID#: _____
Group #: _____ Primary Insured's Name: _____ Birth Date: _____

## CURRENT HEALTH CONDITION

Present complaints if any (be brief, ie. Neck pain, lower back stiffness):

_____

_____

Please rate your pain with the following scale: _____

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did your injury occur during: ☐Work ☐Sports/Play ☐Auto Accident ☐Routine/Household Activity
When did your condition/accident occur: _____ Where did your injury occur: _____
Please explain what happened: _____
Is your condition getting worse? ☐Yes ☐No ☐Constant ☐Comes and Goes
Is your condition interfering with your: ☐Work ☐Sleep ☐Daily Routine? If so, how: _____

_____

Have you been treated by a medical physician for this condition? ☐Yes ☐No
If so, where? _____
_____
_____

Has something similar happened in the past?
☐Yes ☐No Explain: _____
_____
_____
_____

Have you ever been treated by a chiropractor?
☐Yes ☐No

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## OTHER SYMPTOMS

| | | | |
|---|---|---|---|
| ☐Headaches | ☐Face Flushed | ☐Light Bothers Eyes | ☐Feet Cold |
| ☐Neck Pain | ☐Neck Stiff | ☐Loss of Memory | ☐Hands Colds |
| ☐Sleeping Problems | ☐Pins/Needles in Leg | ☐Ears Ring | ☐Upset Stomach |
| ☐Back Pain | ☐Pins/Needles in Arm | ☐Fever | ☐Constipation |
| ☐Nervousness | ☐Numbness in Fingers | ☐Fainting | ☐Loss of Balance |
| ☐Tension | ☐Numbness in Toes | ☐Cold Sweats | ☐Buzzing in Ear |
| ☐Irritability | ☐Shortness of Breath | ☐Loss of Smell | |
| ☐Chest Pains | ☐Fatigue | ☐Loss of Taste | |
| ☐Dizziness | ☐Depression | ☐Diarrhea | |

Are you taking any of the following medications? ☐Nerve Pills ☐Pain Killers (including aspirin) ☐Insulin
☐Muscle Relaxers ☐Blood Thinners ☐Tranquilizers ☐Other(s): _____

Please list any surgeries with dates: _____
_____
_____

List any past serious accidents with dates: _____
_____
_____

Do you take Supplements or Vitamins? ☐Yes ☐No Do you exercise? ☐No ☐Yes _____hours per week
Do you smoke? ☐No ☐Yes How Much? _____ How Long? _____
Are you wearing: ☐Shoe Lifts ☐Inner Soles ☐Arch Supports Are you dieting? ☐No ☐Yes, since _____

**For Women:**
Are you pregnant? ☐No ☐Yes If so, how many weeks? _____

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date: _____