Nature's Way Chiropractic

Dr. Eric Moore
540 Hughes Road, Suite 9, Madison, AL 35758
256-464-0522

ELECTRONIC HEALTH RECORDS INFORMATION Date: _____

Full Name: _____ Date of birth: _____

Address/City/State/Zip:_____

Emergency Contact: _____ Marital status: S M D W Sex: M/F

Spouse's name: _____ Spouse's DOB _____
Occupation:_____ E-mail address:_____
Phone #'s: home_____work_____ cell _____
Parent/Guardian's name(s) if patient is a minor: _____
How did you hear about our office? _____
Race (circle one): American Indian or Alaska Native, Asian, Black, White, Native Hawaiian or Pacific Islander, Other, I decline to answer
Ethnicity (circle one): Hispanic or Latino, Non-Hispanic, I Decline to answer
Smoking Status: Daily, Occasional, Former, Never, I Decline to answer
Preferred Language: _____

Are you currently taking any medications? (including over-the-counter)

Medication Name **Dosage and Frequency (i.e. 5mg once a day)**

_____

_____

_____

_____

Do you have any medication allergies?
Medication Name Reaction Onset Date Comments

_____

_____

INFORMED CONSENT

Please read the following carefully before signing: Informed consent to chiropractic care. I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures, and if necessary diagnostic x-rays on me by the doctors of Nature's Way Chiropractic or anyone authorized by them. I further understand and am informed that, as in all health care, there are some slight risks to treatment and do not expect the doctor to be able to anticipate or explain all risks and combinations; and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known are in my best interest. I have read this consent and intend this consent form to cover the entire course of my care for this condition and any care in the future.

Signature: _____ Witness: _____

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REASON FOR CARE

What is your main reason for consulting our office?

□ Maintenance/Wellness Care (please skip to Confidential Health History)

□ Other (please describe)

_____

_____

How long has this been going on? _____ day(s) _____ week(s) _____month(s) _____ year(s)

Has this ever occurred before? yes no

What makes it worse? _____

What makes it better? _____

Have you sought care for this elsewhere? Yes No If yes, where? _____

CONFIDENTIAL HEALTH HISTORY

Have you ever seen other chiropractors? Yes No If so, who? _____

Please give us the name of your medical doctor: _____

GENERAL

Allergies	Y/N
Anxiety	Y/N
Convulsions	Y/N
Depression	Y/N
Dizziness	Y/N
Fainting	Y/N
Headaches	Y/N
Sleep Loss	Y/N
Tremors	Y/N
Weight Change	Y/N

SKIN

Bruise Easily	Y/N
Rash	Y/N
Varicose Veins	Y/N

GENITO-URINARY

Bedwetting	Y/N
Painful Urination	Y/N
Frequent Urination	Y/N

GENITO-URINARY Continued

Kidney Infection	Y/N
Kidney Stone	Y/N

GASTROINTESTINAL

ANY Problems?	Y/N

MUSCLE/JOINT

Bursitis	Y/N
Bone Fracture	Y/N
Bone Tumor	Y/N
Dislocation	Y/N
Hernia	Y/N
Joint/Bone Infection	Y/N
Low Back Pain	Y/N
Middle Back Pain	Y/N
Neck Pain	Y/N
Osteoporosis	Y/N
Sciatica	Y/N
Spinal Curvature	Y/N
Swollen Joints	Y/N

MUSCLE/JOINT Continued

Pain/Numbness? (circle all that apply)

Arms	Y/N
Elbows	Y/N
Hands	Y/N
Hips	Y/N
Legs	Y/N
Knees	Y/N
Shoulders	Y/N
Ankles	Y/N

INJURIES

Car Accident(s)	Y/N
Loss of Consciousness	Y/N

EENT

Deafness	Y/N
Ear Noises	Y/N
Hoarseness	Y/N
Visual Disturbances	Y/N

Continued on next page ->

CARDIO-VASCULAR

Aneurysm	Y/N
Chest Pain	Y/N
Hardening of Arteries	Y/N
High Blood Pressure	Y/N
Low Blood Pressure	Y/N
Poor Circulation	Y/N
Ankle Swelling	Y/N

RESPIRATORY

Chronic Cough	Y/N
Difficulty Breathing	Y/N

WOMEN ONLY

Difficult Pregnancy	Y/N

MEN ONLY

Prostate Trouble	Y/N

***Please Continue**

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Have you or an *immediate family* member ever experienced:

Diabetes Y/N Stroke Y/N Cancer Y/N Heart Disease Y/N

List all conditions, syndromes, or diseases with which you have been diagnosed.

_____

_____

_____

Please list your past surgeries and/or hospitalizations with approximate date:

_____

_____

_____

_____

□ I choose to decline receipt of my clinical summary after every visit. *These summaries are often blank as a result of the nature and frequency of chiropractic care.*

Patient Signature_____ Date:_____

----------Office Use Only----------

Height _____ Weight_____ Blood Pressure _____/_____

This New Patient Information and Confidential Health History Information has been reviewed by:

D.C. Date