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: ______________________________________

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

RESPIRATORY

Chronic Cough	Y/N
Difficulty Breathing	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

WOMEN ONLY

Difficult Pregnancy	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

MEN ONLY

Prostate Trouble	Y/N

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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: