MOORE CHIROPRACTIC CENTER

707 Sunset Street

Denton, Texas 76201

FILE #_____ DATE___/___/___

CONFIDENTIAL CLINICAL RECORD

GENERAL INFORMATION - PLEASE PRINT

PATIENT NAME _____ MAILING ADDRESS_____

CITY _____ STATE_____ ZIP CODE _____ HOW LONG?_____

HOME PHONE _____ WORK PHONE _____ CELL PHONE_____

OCCUPATION_____

EMAIL_____

WOULD YOU LIKE TO RECEIVE OUR MONTHLY NEWSLETTER AS WELL AS OFFICE UPDATES BY EMAIL: YES____ NO ____

BIRTHDATE_____/_____/_____ SEX: M _____ F _____ MARITAL STATUS: M _____ S_____ D _____ W _____ CHILDREN _____

YOUR EMPLOYER_____ CITY _____ YEARS WITH FIRM _____

SPOUSE'S NAME _____ BIRTHDATE _____/_____/_____

PHYSICIAN _____ DATE OF LAST PHYSICAL _____/_____/_____

DENTIST _____ DATE OF LAST VISIT _____/_____/_____

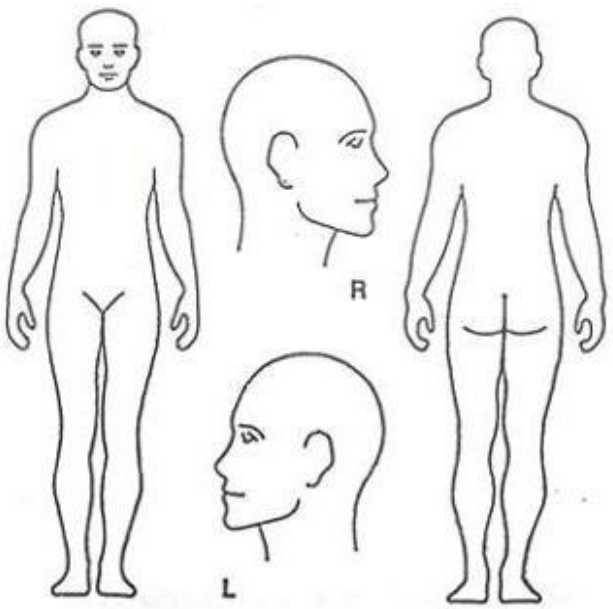
WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL _____

ADDRESS _____CITY_____ STATE_____ ZIP_____PHONE_____

WHO MAY WE CONTACT IN CASE OF EMERGENCY?_____

PHONE _____ HOW OR WHO REFERRED YOU TO OFFICE? _____

IF YOU ARE IN PAIN, PLEASE MARK AN "X" AT THE EXACT LOCATION(S) OF YOUR PAIN ON THE DIAGRAM BELOW. ALSO, IS YOUR PAIN DULL, SHARP, NUMB, BURNING, TINGLING, ACHY?



PAIN SCALE

0 1 2 3 4 5 6 7 8 9 10

NO PAIN **WORST PAIN**

MAJOR COMPLAINT

DESCRIBE IN YOUR OWN WORDS YOUR PROBLEM AND HOW IT STARTED._____

_____

_____

_____

WHEN DID YOUR SYMPTOMS APPEAR?_____

_____

_____

EVER HAD THIS PROBLEM OR SIMILAR PROBLEM BEFORE?
NO___ YES___ EXPLAIN:_____

_____

HAVE YOU EVER RECEIVED ANY TREATMENT FOR THIS CONDITION? _____ IF YES, WHEN, WHERE AND WHAT WERE THE RESULTS? _____

_____

IS THE CONDITION PROGRESSIVELY GETTING:
BETTER ___ WORSE ___ THE SAME___

WHAT MAKES IT BETTER? _____

WHAT MAKES IT WORSE? _____

PLEASE COMPLETE REVERSE SIDE

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PATIENT NAME _____ FILE#_____ DATE _____

HOW HAS THIS PROBLEM INTERFERRED WITH YOUR LIFE:

A. HOME_____

B. WORK_____

C. RECREATION_____

D. REST & SLEEP_____

PAST HISTORY

HAVE YOU EVER BEEN INVOLVED IN ANY PREVIOUS ACCIDENTS OR INJURIES OF ANY KIND?

NO___, YES___-GIVE DATES AND DETAILS:_____

_____

_____

_____

HAVE YOU EVER BEEN PREVIOUSLY TREATED FOR NECK AND/OR BACK PROBLEM? PLEASE EXPLAIN:

_____

_____

_____

HAVE YOU BEEN PREVIOUSLY TREATED BY A DOCTOR OF CHIROPRACTIC? PLEASE EXPLAIN:

_____

_____

PAST SURGICAL HISTORY

_____

_____

_____

HAVE YOU HAD ANY SIGNIFICANT MEDICAL PROBLEMS? (DIABETES; HEART; LUNGS; HIGH BLOOD PRESSURE; BROKEN BONES; CANCER; ETC.)

_____

_____

_____

HAVE ANY OF YOUR BLOOD RELATIVES HAD? (DIABETES; HEART; LUNGS; HIGH BLOOD PRESSURE; CANCER; ETC.)

_____

_____

DID YOU ENJOY GOOD HEALTH PRIOR TO THIS CONDITION?

YES___, NO___ - EXPLAIN:_____

_____

LIST ALL MEDICATIONS, VITAMINS AND/OR HERBS YOU ARE PRESENTLY TAKING:_____

_____

FOR WOMEN ONLY: DATE OF LAST PERIOD:_____/_____/_____ ARE YOU PREGNANT? YES____; NO____

SIGNATURE:_____

PATIENT/GUARDIAN

DOCTORS INITIALS:_____