

### Patient Information

|                             |   |                       |
|-----------------------------|---|-----------------------|
| Name:                       | <input type="checkbox"/> Male <input type="checkbox"/> Female | <b>Date of Birth:</b> |
| Name I Prefer to be Called: | Marital Status: S M D W                                       |                       |
| Address:                    | Height:   | Weight:               |
| City: St: Zip:              | Employer Name:  |                       |
| Home Phone:                 | Employer Address:   |                       |
| Cell Phone:                 | City: St: Zip:  |                       |
| Email:                      | Occupation:   |                       |
| SSN:                        | Work Phone:   |                       |

|                                |                |
|--------------------------------|----------------|
| Name of Spouse:                | Date of Birth: |
| Spouse's Employer:             | Work Phone:    |
| Parent/Guardian:               | Relationship:  |
| Emergency Contact Information: |                |
| Name:                          | Relationship:  |
| Address:                       | Phone:         |

### Insurance/Billing Information

|  |                         |
|--|-------------------------|
| Method of Payment: <input type="checkbox"/> Self Pay or <input type="checkbox"/> Insurance |                         |
| Person responsible for balances due:   |                         |
| Primary Insurance:   | Secondary Insurance:    |
| Primary Name on policy:  | Primary Name on policy: |
| Date of Birth:   | Date of Birth:          |
| Phone Number:  | Phone Number:           |
|  |                         |

### Consent to Treat

I authorize Moulds and Stern Family Chiropractic, its physicians, Dr. Ryan Moulds and Dr. Jason Stern, and agents, together with any other company designated by Moulds and Stern Family Chiropractic to perform physical examinations, chiropractic adjustments, and/or other treatment deemed necessary by the treating physician, including but not limited to any required examinations, x-rays, physical therapy, and other diagnostic/laboratory testing. I understand that as a patient of Moulds and Stern Family Chiropractic, I am authorizing the staff to proceed with medically necessary examinations, diagnostic tests, and treatments. Furthermore, the risks associated with chiropractic care, physical rehabilitation, and/or physical modalities have been explained to my satisfaction. My signature on this document attests to my understanding and that the services for which claims may be submitted have been explained to me. I further authorize Moulds and Stern Family Chiropractic to disclose to the above-named insurer and its designated representatives test results and physical findings made during the course of these examinations and/or treatment, including but not limited to medical history, treatment information, laboratory/diagnostic test results, and physical examination findings. I hereby direct the insurer to pay, without equivocation, directly to Dr. Ryan Moulds or Dr. Jason Stern any and all benefits due as a result of this claim. I am also aware that I am responsible for any charges and/or any balance not covered by my insurance. By signing this authorization, I acknowledge that I have read this form, or have had it read to me, that I fully understand its contents, that I have been given ample opportunity to ask questions, and that my questions have been answered satisfactorily.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Your Current Condition:** Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

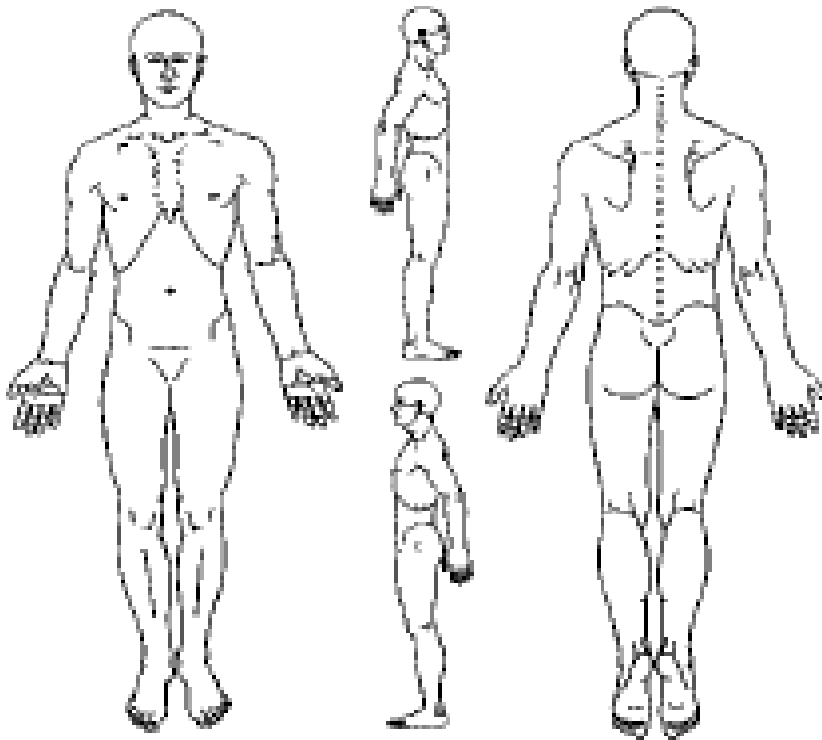
**Please indicate your current condition.**

NEW injury, illness or problem?  Flare-up of a previous condition?  Continuation of current problem?

**Is your condition the result of Work-related injury?**  YES  NO **An automobile accident?**  YES  NO

Please explain your condition. When did the problem/pain begin? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Where is your pain?**



**What type of pain are you experiencing?**

- Dull
- Aching
- Spasm
- Sharp
- Shooting
- Burning
- Stabbing
- Numbness
- Tingling
- Other \_\_\_\_\_

**DOES THIS PAIN RADIATE, SHOOT, OR TRAVEL IN YOUR BODY?**  YES  NO

If so, where? \_\_\_\_\_

**PAIN RATING:** Please rate your pain for each area of the body where you are experiencing symptoms.

0   1   2   3   4   5   6   7   8   9   10  
 NONE MINIMAL MILD MODERATE SEVERE VERY SEVERE

Write the number from the scale above next to the area of complaint.

HEAD: \_\_\_\_\_ NECK: \_\_\_\_\_ UPPER-BACK \_\_\_\_\_ MID BACK \_\_\_\_\_ LOWER BACK \_\_\_\_\_

SHOULDER: LFT \_\_\_/ RGHT\_\_\_ ELBOW/WRIST/ HAND: LFT\_\_\_/ RGHT\_\_\_ KNEE: LFT\_\_\_/ RGHT\_\_\_

ANKLE/ FOOT: LFT\_\_\_/ RIGHT\_\_\_

**Please indicate the frequency of your pain?**

INTERMITTENT

OCCASIONAL

FREQUENT

CONSTANT

**The condition is getting progressively?** **BETTER** **STAYING THE SAME** **WORSE**

What makes it worse? \_\_\_\_\_

**Is the condition affecting you ability to perform your activities of daily living? Circle or write below**

**For example: bending, lifting, twisting, sitting, standing, driving, sitting at computer, holding objects, performing work duties, home care duties, child care duties, personal hygiene?**  **YES**  **NO**

\_\_\_\_\_  
\_\_\_\_\_

**Other doctors seen for this condition:** \_\_\_\_\_

**Anything else the doctor should know?**  **YES**  **NO**

**If yes please explain:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Sign Below Please.**

**Consent to Treat**

I authorize Moulds and Stern Family Chiropractic, its physician Dr's. Ryan Moulds and Jason Stern and agents, together with any other company designated by Moulds and Stern Family Chiropractic to perform a physical examination, chiropractic adjustments and/or other treatment deemed necessary by the treating physician, including but not limited to any required examination, x-rays, physical therapy and other diagnostic/laboratory testing. I understand that as a patient of Moulds and Stern Family Chiropractic, I am authorizing the staff to proceed with medically necessary examinations, diagnostic test, and treatments. Furthermore, the risk associated with chiropractic care and or physical rehabilitation, physical modalities have been explained to my satisfaction. My signature on this document attests to my understanding and that the services for which claims may be submitted have been explained to me. I further authorize Moulds and Stern Family Chiropractic to disclose the above named insurer and its designated representatives, test results and physical findings made during the course of this examination and/ or treatment, including but not limited to, medical history, treatment information, laboratory/ diagnostic tests results and physical examination findings. I hereby direct the insurer to pay, without equivocation, directly to Moulds and Stern Family Chiropractic, Drs. Ryan Moulds and Jason Stern, any and all benefits due as a result of this claim. I am also aware that I am responsible for charges and/or balance not covered by my insurance. By signing this authorization, I acknowledge that I have read, or had this form read and explained to me, that I fully understand its contents, and that I have been given ample opportunity to ask questions, and that my questions have been answered satisfactory.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date



# REPORT OF MEDICAL HISTORY

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. If you cannot remember specific details, please provide your best guess. Please complete all pages of this form and if you should need any assistance let us know.

**Review of Systems:** Please mark or circle any persistent symptoms you have had in the past few months. Read through every section and check "No problems" if none of the symptoms apply to you.

**General**

- Unexplained weight loss/ gain
- Unexplained fatigue / weakness
- Fall asleep during day when sitting
- fever, chills
- No problems**

**Skin**

- New or change in mole
- rash / itching
- No problems**

**Breast**

- Breast Lump / pain / nipple discharge
- No problems**

**Ears/Nose/Throat**

- Nosebleeds, trouble swallowing
- frequent sore throat, hoarseness
- hearing loss/ ringing in ears
- No problems**

**Eyes**

- change in vision/eye pain / redness
- No problems**

**Cardiovascular**

- chest pain / discomfort
- palpitations (fast or irregular heartbeat)
- No problems**

**Respiratory**

- cough/ wheeze
- snoring /altered breathing during sleep
- short of breath with exertion
- no problems**

**Gastrointestinal**

- Heartburn/reflux/indigestion
- blood or change in bowel
- constipation
- no problems**

**Genitourinary**

- Leaking urine
- blood in urine
- nighttime urination or increased frequency
- discharge; penis or vagina
- concern with sexual function
- no problems**

**Musculoskeletal**

- Neck pain
- back pain
- muscle/ joint pain \_\_\_\_\_
- no problems**

**Endocrine**

- heat or cold sensitivity
- no problems**

**Hematologic/Lymphatic**

- Swollen glands
- Easy bruising
- no problems**

**Neurological**

- Headache
- Memory Loss
- Fainting
- Dizziness
- Numbness /tingling
- unsteady gait
- frequent falls
- no problems**

**Allergic /Immune**

- Hay fever/ allergies
- Frequent infections
- no problems**

**Psychiatric**

- Anxiety /stress/irritability
- sleep problems
- lack of concentration
- no problems**

**Women Only**

- Pre-menstrual symptoms (bloating, cramps, irritability)
- Problem with menstrual period
- Hot flashes/night sweats
- Pregnant**  months
- no problems**

Please List below if you have any other conditions or symptoms not listed above

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**PERSONAL MEDICAL HISTORY:** Do you have now or have you ever had any of the following check or circle below

|   |                         |                          |                            |                          |                         |
|---|-------------------------|--------------------------|----------------------------|--------------------------|-------------------------|
| <input type="checkbox"/>                      | Diabetes                | <input type="checkbox"/> | Pneumonia                  | <input type="checkbox"/> | Stomach disorder/ Ulcer |
| <input type="checkbox"/>                      | High Blood pressure     | <input type="checkbox"/> | Asthma                     | <input type="checkbox"/> | Rheumatologic disorder  |
| <input type="checkbox"/>                      | High Cholesterol        | <input type="checkbox"/> | Emphysema                  | <input type="checkbox"/> | Tuberculosis            |
| <input type="checkbox"/>                      | Thyroid Disorder _____  | <input type="checkbox"/> | Stroke                     | <input type="checkbox"/> | HIV/AIDS/Hepatitis      |
| <input type="checkbox"/>                      | Cancer (type) _____     | <input type="checkbox"/> | Epilepsy (Seizures)        | <input type="checkbox"/> | Pancreatic Disorder     |
| <input type="checkbox"/>                      | Skin Disorder _____     | <input type="checkbox"/> | Liver Disease _____        | <input type="checkbox"/> | Dizziness/vertigo       |
| <input type="checkbox"/>                      | Lung Problem            | <input type="checkbox"/> | Kidney Disease/stone _____ | <input type="checkbox"/> | Joint Problem<br>_____  |
| <input type="checkbox"/>                      | Crohn's disease         | <input type="checkbox"/> | Blood disorders            | <input type="checkbox"/> | Spinal related disorder |
| <input type="checkbox"/>                      | Colon disorder/ colitis | <input type="checkbox"/> | Gallbladder disease        | <input type="checkbox"/> | Liver Disease           |
| <input type="checkbox"/>                      | Heart Problems          | <input type="checkbox"/> | Hepatitis                  | <input type="checkbox"/> | heart problems          |
| <b>Other Medical Condition</b> (please list): |                         |                          |                            | <input type="checkbox"/> | Osteoporosis            |
|   |                         |                          |                            |                          |                         |
|   |                         |                          |                            |                          |                         |

**FAMILY ILLNESS HISTORY:**

(Has any member of your family had any of the following illness)

| Illness            | Which family member? | Illness                | Which family member? |
|--------------------|----------------------|------------------------|----------------------|
| Lung Disease       | _____                | Heart disease          | _____                |
| Cancer             | _____                | High blood pressure    | _____                |
| Kidney Disease     | _____                | Stroke                 | _____                |
| Diabetes           | _____                | Nervous system disease | _____                |
| Liver Disease      | _____                | Joint disorders        | _____                |
| Rheumatoid disease | _____                | Other serious illness  | _____                |

**SURGICAL HISTORY:** ( Please list all surgical procedures and dates. If you cannot remember the exact date please estimate )

|  |
|--|
|  |
|  |
|  |

**MEDICATIONS:** Please list (or show us your own printed records) all prescription and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. If you need more room please use the back of this page

|                    |   |
|--------------------|---|
| Name of medication | <input type="checkbox"/> Take no medications            |
|                    |   |
|                    |   |
|                    |   |
|                    | <input type="checkbox"/> Check her if used back of page |

**ALLERGIES:**

None

**SOCIAL HISTORY: (Please select use of the following)**

|  |  |
|--|--|
| <b>Tobacco Use:</b> Do you smoke? Y or N         | <b>Caffeine Use:</b> Do you drink caffeine? Y or N |
| <b>Alcohol Use:</b> Do you drink alcohol? Y or N | Name _____   |