Moulds & Stern Family Chiropractic

5599 North W Street
Pensacola, Florida 32505
850.435.9200

## Patient Information

| | |
|---|---|
| Name: | ☐ Male ☐ Female **Date of Birth:** |
| 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:<br>Name: | Relationship: |
| Address: | Phone: |

## Insurance/Billing Information

| | |
|---|---|
| Method of Payment: ☐ Self Pay or ☐ 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: _____

Moulds&Stern Family Chiropractic

**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?

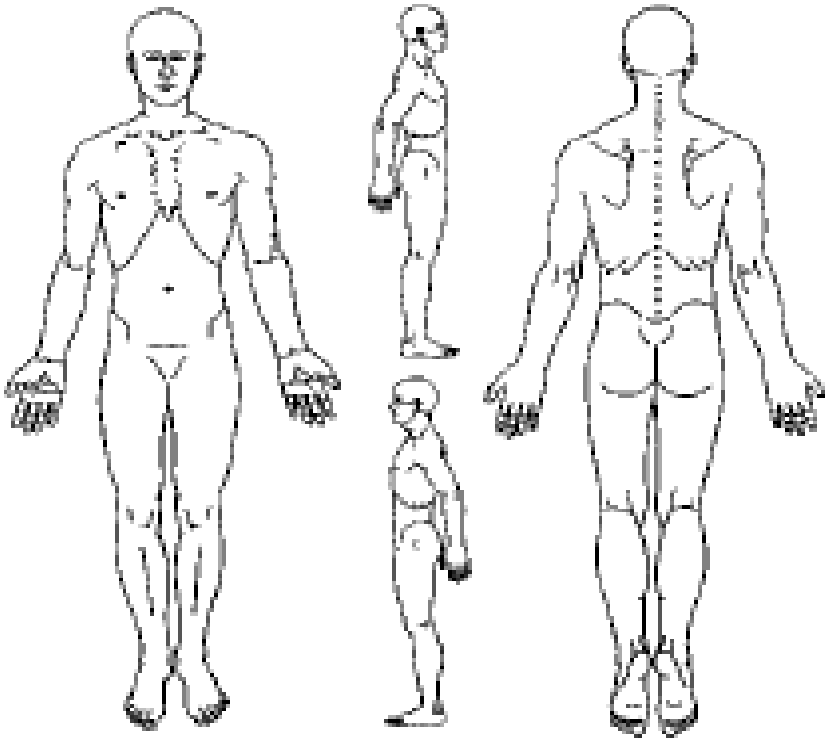
**Is your condition the result of Work-related injury? ☐ YES ☐ NO An automobile accident? ☐ YES ☐ NO**

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

Moulds & Stern Family Chiropractic

5599 N. W Street
Pensacola, Florida
32505
850-435-9200

**Doctor Reviewed**

X _____

# 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**

_____

_____

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

| | | |
|---|---|---|
| ☐ Diabetes | ☐ Pneumonia | ☐ Stomach disorder/ Ulcer |
| ☐ High Blood pressure | ☐ Asthma | ☐ Rheumatologic disorder |
| ☐ High Cholesterol | ☐ Emphysema | ☐ Tuberculosis |
| ☐ Thyroid Disorder _____ | ☐ Stroke | ☐ HIV/AIDS/Hepatitis |
| ☐ Cancer (type)_____ | ☐ Epilepsy (Seizures) | ☐ Pancreatic Disorder |
| ☐ Skin Disorder _____ | ☐ Liver Disease _____ | ☐ Dizziness/vertigo |
| ☐ Lung Problem | ☐ Kidney Disease/stone_____ | ☐ Joint Problem _____ |
| ☐ Crohn's disease | ☐ Blood disorders | ☐ Spinal related disorder |
| ☐ Colon disorder/ colitis | ☐ Gallbladder disease | ☐ Liver Disease |
| ☐ Heart Problems | ☐ Hepatitis | ☐ heart problems |
| | | ☐ Osteoporosis |

**Other Medical Condition** (please list):

**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 ☐ Take no medications

☐ Check her if used back of page

**ALLERGIES:** ☐ None

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

**Tobacco Use:** Do you smoke? Y or N

**Caffeine Use:** Do you drink caffeine? Y or N

**Alcohol Use:** Do you drink alcohol? Y or N

Name _____