For Office Use Only
Date: ____________________
Acct #:____________________

Moeckel Chiropractic Physicians
Patient Intake Form

Name: ______________________________________Maiden:______________________

Date of birth:________ Sex:[ ]Male [ ]Female Address____

City_________________________ State_______ Zip:_____________ Phone:_______________________

Cell:___________________________ Email:____________________________________

Social Security Number________________________ Marital Status:___________________ Number of children:__________

Employer:________________________ Occupation:_________________ Work Phone:______________________________

Spouse / Guardian Info: Name:__________________________________ Social Security Number:______________________

Employer:________________________ Occupation:_________________ Cell:_______________________

Briefly describe and give location of the problems that bring you in today :_______________________________________

____

When did this problem start?___________________ Have you ever this problem before?❑Yes ❑No When?_____________

Was this an injury? ❑ Job Related ❑Auto Accident ❑Personal Injury ❑Other: __________________________________

Has the accident been reported? ❑Yes ❑No If so, to whom? ❑To Employer ❑Auto Carrier ❑Other: ______________

SYMPTOMS WHEN THIS STARTED

List symptoms and location experienced right after problems started and choose the severity level associated with each symptom

_____________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

_____________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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SYMPTOMS TODAY **(use back if needed→)**

List symptoms you are experiencing today: Choose the severity level associated with each symptom

_____________________________________ ❑(1) Very Mild ❑(2) ❑(3) ❑(4) ❑(5) ❑(6) ❑(7) ❑(8) ❑(9) ❑(10) Remarkably Severe

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(use back if needed→)

Have seen any other doctor or medical professional for this condition? ❑No ❑Yes, Who?_____________________________

When was last visit and how many visits with above mentioned doctor?____

Where you admitted to the hospital: ❑No ❑Yes, what hospital?________________________________When?___________

List any tests, studies or medications received for this condition:

❑Tests/Studies (X-Ray, MRI or CT): ____

❑Medications: ____

Do you have any current work restrictions due to this condition?

Off work: ❑Yes ❑No ❑Previously From: ____________________ To: ____________________

Light duty: ❑Yes ❑No ❑Previously (If yes, what are/were your restrictions?) ______________________________

What type of work do you do?____

Do you suffer from any condition other than that for which you are now consulting us? ❑Yes ❑No __________________

____

List any past conditions you may have had: ____________________

Have you ever seen a Chiropractor before?❑No ❑Yes, Who?____________________ Last treatment date______________

HABITS		**EXERCISE**	**FAMILY HISTORY**	Diabetes	Cancer	Back Pain	Other
❑Smoking	Packs/day: _____	❑None					
❑Drinking	Alcohol: (Cups/day): _____	❑Moderate	Mother	❑	❑	❑	❑__________
❑Coffee	Cups/Day: _______	❑Daily	Father	❑	❑	❑	❑__________
❑Soft Drink	Bottles or Cans/Day: _____	Type: _________	Brother(s)	❑	❑	❑	❑__________
❑Water	Cups/Day: _______	______________	Sister(s)	❑	❑	❑	❑__________

Are you taking any medication (prescription or over-the-counter), home remedies, vitamins, minerals, etc? ❑Yes ❑No If yes, which ones?: ____________________

Have you taken any medications in the past? ❑Yes ❑No If yes, which ones?: ____________________

Do you have allergies? ❑Yes ❑No If yes, please explain: ____________________

SURGERIES

Have you ever had any surgeries? ❑No ❑Yes, please list type and the approximate date of surgery.

____

____________________(use back if needed→)

Have you ever had X-rays or MRI'S taken? ❑Yes ❑No When? ___________ By Whom? ____________________

For what ailments were these X-rays taken? ____________________

Accidents

List any motor vehicle accidents with approx date____________________

____________________(use back if needed→)

List any Major falls or hospitalizations with approx date____________________

Please check the box for each current or past symptom listed. (use back if needed→)

GENERAL SYMPTOMS	GASTRO-INTESTINAL	E.E.N.T.	RESPIRATORY
❑ Allergy(What) ____ ________________	❑ Belching or Gas	❑ Asthma	❑ Chest Pain
	❑ Colon Trouble	❑ Deafness	❑ Chronic Cough
❑ Bronchitis	❑ Constipation	❑ Earache	❑ Difficulty Breathing
❑ Chills (Constant)	❑ Diarrhea	❑ Ear Discharge	❑ Spitting Blood
❑ Convulsions	❑ Gall Bladder Trouble	❑ Ear Noises	❑ Spitting Phlegm
❑ Dizziness	❑ Hemorrhoids (piles)	❑ Thyroid Problems	
❑ Fainting	❑ Jaundice	❑ Frequent Colds	**GENITO-URINARY**
❑ Fatigue	❑ Liver Trouble	❑ Hay Fever	❑ Bed Wetting
❑ Headache	❑ Nausea	❑ Nasal Obstruction	❑ Blood in Urine
❑ Loss of Sleep	❑ Stomach Pain	❑ Nose Bleeds	❑ Frequent Urination
❑ Loss of Weight	❑ Vomiting	❑ Pain in Eyes	❑ Inability to Control Urine
❑ Nervousness	❑ Vomiting Blood	❑ Poor Vision	
❑ Night Sweats	❑ Heart Burn	❑ Blurred Vision	❑ Kidney Infection

❑ Numbness or Pain in arms/legs/hands	❑ Bloody Stools	❑ Sinusitis	❑ Kidney Stones
	❑ Acid Reflux	❑ Sore Throats	❑ Painful Urination
❑ Wheezing	❑ Irritable Bowel	❑ Tonsillitis	❑ Prostate Trouble
MUSCLES & JOINTS	**CARDIO-VASCULAR**	**SKIN OR ALLERGIES**	**FOR FEMALES ONLY**
❑ Backache	❑ High Blood Pressure	❑ Bruising Easily	❑ Cramps
❑ Foot Trouble	❑ Low Blood Pressure	❑ Dryness	❑ Hot Flashes
❑ Hernia	❑ Chest Pain	❑ Eczema	❑ Irregular Cycle
❑ Pain Between shoulders	❑ Heart Trouble	❑ Hives or Allergy	❑ Painful Periods
❑ Painful Tail Bone	❑ Poor Circulation	❑ Itching	❑ Vaginal Discharge
❑ Stiff Neck	❑ Rapid Heart	❑ Sensitive Skin	Pregnant ❑No ❑Yes
❑ Spinal Curvature	❑ Slow Heart	❑ Skin Eruptions	Due date?________________
❑ Swollen Joints	❑ Strokes		Last menstrual cycle________
❑ Tremors	❑ Swelling Ankles		Last pap date_______________
❑ Twitching			

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❑Appendicitis	❑Anemia	❑Heart Disease	❑Arthritis	❑Pneumonia	❑Measles
❑Goiter	❑Epilepsy	❑Rheumatic Fever	❑Mumps	❑Influenza	❑Mental Disorder
❑Polio	❑Chicken Pox	❑Pleurisy	❑Lumbago	❑Tuberculosis	❑Diabetes
❑Alcoholism	❑Eczema	❑Whooping Cough	❑Cancer	❑Venereal Disease	❑HIV Positive

Any other diagnosis not listed here?

Personal Medical Information Consent

The Health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use the personal information in your medical records for any reason. This consent form gives us permission to use your Protected Health Information (PHI) to carry out treatment, receive and/or as part of health care operations of our practice. HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available at the front desk for you to read. You have the right to revoke, in writing, this consent form at any time, although any services preformed prior to the revocation of this consent are covered by this consent. HIPAA gives the patient a right to add restrictions to the release of Protected Health Information. We as an office do not have to agree to these restrictions, but if we do they are legally binding. You have the right to revoke, in writing, this consent form at any time, although any services preformed prior to revocation of this consent are covered by this consent. Restrictions:

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: ____ Date: ______________________

Right to revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices, These changes in our office's polices and practices may be required by changes in federal and state laws and regulations. Upon receipt, we will provide you with the most recent notice on an office visit. The revised policies and practices will be applied to all protected health information we maintain.

Doctor's/Staff's Signature: ____ Date: ______________________