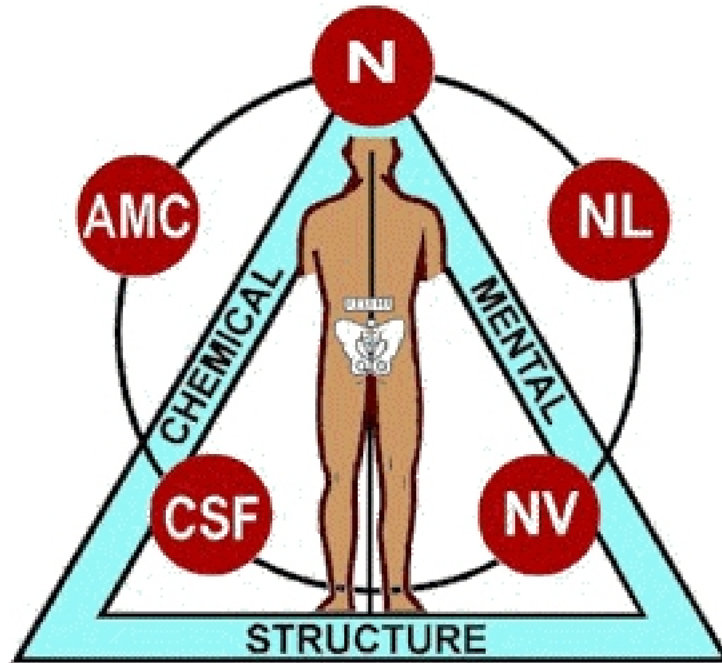
Welcome to Moss Family Chiropractic.

This is your confidential health record.



The purpose of our office is to help as many people as possible to achieve health naturally, and to educate them about Chiropractic so they may educate others.

We are concerned with you and how your body is functioning. Our examination is designed to evaluate how your body is functioning and to determine if we can help you. If we feel we can help you, we will want see if we can improve your function. Then we will want to compare a series of adjustments to determine how your body stabilizes. We will then give you our recommendation for your personal corrective care plan. We look forward to accompanying you on your journey to health. You are the healer and we will aim to help your body do what your Creator designed it to do.

Sincerely,

Dr. Paul R. Moss, D.C. and Staff

Moss Family Chiropractic

Confidential Patient Health Record

Name______________________________________ Birth Date_______________ Age________ Sex _______

Address____ Home Phone __________________________

City__________________________________ State _________ Cell Phone ____________________________

Zip Code _______________________ E-mail Address ____

Social Sec. # ________________________________ Driver License _________________________________

Circle One: Married Single Widowed Divorced Separated

Business Employer ____________________________ Type of Work __________________________________

Business Phone _______________________________ Spouse's Social Sec. # _________________________

Name of Spouse ______________________________ Spouse's Employer ____________________________

Type of Work ________________________________ Business Phone _______________________________

Name and Ages of Children ____

____**Referred by:** _______________________________

Emergency contact: _________________________ Number __________________ Relationship ___________

I understand that I am responsible for my bill. I would like info to send to an insurance company. ☐No ☐Yes

Insurance information ____

Was this condition due to an auto accident? ☐No ☐Yes ***If yes, please fill out a separate Auto Accident Form.***

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come only for symptomatic relief of pain or discomfort (relief care). Others are interested in having the CAUSE of their problems as well as the symptoms corrected and relieved (corrective care). The Doctor will weigh your needs and desires when recommending your treatment program.

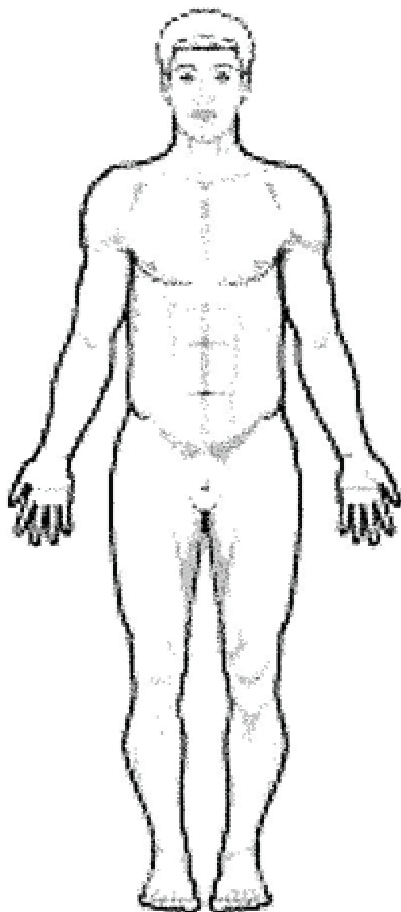
☐ I want relief care only
☐ I want corrective care
☐ I want the doctor to select the type of care appropriate for my condition

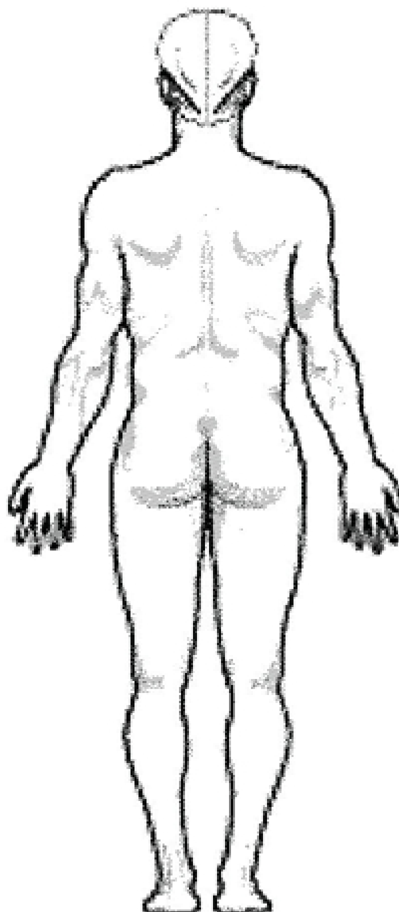
Patient Signature ____ Date __________________

Name:____ Date:_________________

Please list and describe your problems and draw them on the chart below.

1. ____
2. ____
3. ____
4. ____





Grade Your Problems from 1 (gone) to 10 (very severe problem)

Problem 1 ____ Problem 2 ____

Problem 3 ____ Problem 4 ____

How long have you suffered from these problems?
Problem 1. __________________
Problem 2. __________________
Problem 3. __________________
Problem 4. __________________
My problems are made worse by:
1.__________________________
2.__________________________
3.__________________________
4.__________________________
My problems are made better by:
1.__________________________
2.__________________________
3.__________________________
4.__________________________

Is this due to an on-the-job injury? ☐ No ☐Yes ☐ I have an active Worker's Comp case.

Have you seen another Physician? ☐ No ☐Yes Who?______________________________
Type of Treatment: ____
Results: ____

Have you had X-ray or MRI studies within the past 6 months? ☐ No ☐Yes, where?_____________
List of Medications: ____
____
____
Vitamins, minerals, herbs: ____
____
Dates/Types of Surgeries: ____
____
List any Scars: ____
Major Dental work and age when performed: ____

How many times do you urinate during the day? _______ during the night _________
How often do you have a bowel movement? _______ times a day. __________ times a week.

Do you have a problem with fluid retention? ☐ No ☐ Yes Where? ______________________________

Do you have any sexually related problems? ☐ No ☐ Yes What problem? ____________________

Abdominal bloating	□ daily □ weekly □monthly	Describe________________________
Abdominal tenderness	□ daily □ weekly □monthly	Describe________________________
Allergies airborne	□ daily □ weekly □monthly	Describe________________________
Allergies food	□ daily □ weekly □monthly	Describe________________________
Allergies skin	□ daily □ weekly □monthly	Describe________________________
Appetite excessive	□ daily □ weekly □monthly	Describe________________________
Appetite loss	□ daily □ weekly □monthly	Describe________________________
Back pain	□ daily □ weekly □monthly	Describe________________________
Blood in urine	□ daily □ weekly □monthly	Describe________________________
Blood pressure, high	□ daily □ weekly □monthly	Describe________________________
Blood pressure, low	□ daily □ weekly □monthly	Describe________________________
Bruising easily	□ daily □ weekly □monthly	Describe________________________
Chest pain	□ daily □ weekly □monthly	Describe________________________
Constipation	□ daily □ weekly □monthly	Describe________________________
Cough, non-productive	□ daily □ weekly □monthly	Describe________________________
Cough, productive	□ daily □ weekly □monthly	Describe________________________
Difficult breathing	□ daily □ weekly □monthly	Describe________________________
Difficult swallowing	□ daily □ weekly □monthly	Describe________________________
Edema/ swelling	□ daily □ weekly □monthly	Describe________________________
Diarrhea	□ daily □ weekly □monthly	Describe________________________
Fast heart beat	□ daily □ weekly □monthly	Describe________________________
Fatigue	□ daily □ weekly □monthly	Describe________________________
Fever	□ daily □ weekly □monthly	Describe________________________
Headache	□ daily □ weekly □monthly	Describe________________________
Increased urination	□ daily □ weekly □monthly	Describe________________________
Indigestion	□ daily □ weekly □monthly	Describe________________________
Jaundice	□ daily □ weekly □monthly	Describe________________________
Menstrual problems	□ daily □ weekly □monthly	Describe________________________
Muscle weakness	□ daily □ weekly □monthly	Describe________________________
Nausea	□ daily □ weekly □monthly	Describe________________________
Neck veins prominent	□ daily □ weekly □monthly	Describe________________________
Numbness, pins and needles	□ daily □ weekly □monthly	Describe________________________
Pain above pubic bone	□ daily □ weekly □monthly	Describe________________________
Rapid weight change	□ daily □ weekly □monthly	Describe________________________
Skin blue (Cyanosis)	□ daily □ weekly □monthly	Describe________________________
Sore throat	□ daily □ weekly □monthly	Describe________________________
Sick	□ daily □ weekly □monthly	Describe________________________
Strain to urinate	□ daily □ weekly □monthly	Describe________________________
Vaginal discharge	□ daily □ weekly □monthly	Describe________________________
Vomiting	□ daily □ weekly □monthly	Describe________________________

List all major diseases/ conditions you have been treated for and at what age(s).

____

____

____

Mark any of these a grandparent, parent, or sister/brother have been treated for:

☐Diabetes ☐ Cancer ☐Tuberculosis ☐Heart Disease ☐High Blood Pressure ☐Hypoglycemia

☐Stroke ☐ Liver Disease ☐Other ______________________________

Females only: Date of Last Menstrual Period ________________Number of Days you menstruate ___

Is your Cycle regular? ☐ No ☐Yes Do you suffer from PMS? ☐No ☐Yes