Motion Dynamics CHIROPRACTIC

First name	Last name	Date of Birth
Home phone	Cell phone	Work phone
e-mail address	Preferred Communication: (circle) H C W email	
Street address	Apt/Suite #	
City	State	Zip

I would like to be reminded of appointments by: ◯ Text ◯ E-mail ◯ None

SSN	Gender: ◯ Male ◯ Female	Preferred Language: ◯ English ◯ Spanish ◯ Other:_____

Emergency Contact Name	Phone	Relationship

Marital status	Race/Ethnicity
◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated	◯ Am. Indian/ Alaska Native ◯ Hispanic/Latino ◯ Asian ◯ Native Pacific Islander ◯ Black ◯ White ◯ Other _____

Do you have any children/grandchildren at home? ◯ Yes ◯ No Ages: _____

How did you hear of us? ◯ Internet search ◯ Our website ◯ Walk-in/ Signage ◯ Event _____
◯ Referral : by _____ ◯ Other _____

Employer/Company Name	phone number
Street Address	suite/unit #

City	State	Zip

Job Title/Position	Currently working
	◯ Yes ◯ No Date stopped working_____

Insurance

Do you have health insurance that you wish us to consider?
Yes ◯ No ◯ specify: Primary insurance Co. _____

Secondary Insurance Co. _____

Financially Responsible Party (Person under whom insurance is issued/ if no insurance, person who will pay)

Self ◯ Other ◯ if other, please complete section below

First Name	Last Name	Date of Birth
Phone	e-mail	relationship
Street Address		apt/suite
City	State	Zip

Medical History

Do you smoke? ◯ Yes ◯ No	If yes, How often?
Do you drink alcohol? ◯ Yes ◯ No	If yes, How often?
How would you describe your overall stress level**?** ◯ Low ◯ Medium ◯ High	Stressors:
Do you exercise? ◯ Yes ◯ No	If yes, How often?
How many glasses of water do you typically drink per day?	How many hours of sleep per night do you get regularly?
Have you ever been hospitalized? ◯ Yes ◯ No	Have you had any surgeries? ◯ Yes ◯ No
If yes, please provide details:	
Do you take any medications or supplements? ◯ Yes ◯ No	
If yes, please list medications and dosages (how much & how often):	
Do you have any allergies? ◯ Yes ◯ No Do you require medical treatment for your allergies? ◯ Yes ◯ No	

Medical Detail

Is there a possibility that you may be pregnant? ◯ Yes ◯ No Date of last menstrual cycle _____

Please check if you have or have had any of the following:

◯Headaches/migraines	◯ Neck Pain	◯ Upper Back Pain	◯ Shoulder Pain	◯ Midback Pain
◯ Low Back Pain	◯ Osteoarthritis	◯Rheumatoid Arthritis	◯ Arm/Leg Pain	◯ Jaw Pain/Clicking
◯ Dizziness	◯ Fatigue	◯ Fibromyalgia	◯ Asthma	◯ Numbness/Tingling
◯ Allergies	◯ High Cholesterol	◯ Digestive Problems	◯ Joint Pain/Stiffness	◯ Menstrual Problems
◯ Pinched nerve	◯ Loss of sleep	◯ Glaucoma	◯ Diabetes	◯ High Blood Pressure
◯ Cancer	◯ Nervousness	◯ AIDS/HIV	◯ Osteoporosis	◯ Heart Disease
◯Paralysis	◯ Parkinson's	◯ Kidney Disease	◯ Prostate Problems	◯ Disc Degeneration
◯ Sciatica	◯ Sinus Pain	◯ Pacemaker	◯ Stroke	◯ Thyroid problems
◯ Tumors/Growths	◯ Urinary Problems	◯ Vascular Disease	◯ Vision Problems	◯ Herniated Disc
◯ Other:				

Reason for you visit:

◯ Wellness and Health Maintenance		
◯ Injury, Pain, Ailment		Date of Injury: (when did your pain start)
◯ Accident ◯ Auto ◯ Other	Date of Accident:	State where accident occurred:

By signing below, I affirm that the questions on this form have been answered correctly, to the best of my knowledge.

_____ _____ _____

Print Name *Signature* *Date*

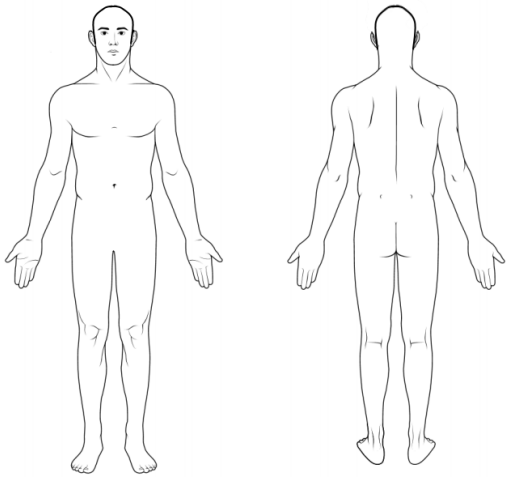
AUTHORIZATION FOR CARE OF MINOR Consent to treat a minor: I hereby authorize the doctor(s) at Motion Dynamics Chiropractic and whomever they designate as assistants to administer care to child.
Name of Minor Child:
Name of parent/guardian (print)
Parent/Guardian signature
Date:

Are you currently being treated for any othe medical conditions I should know about? ◯**Yes** ◯ **No**

List current complaints separately in order of severity.

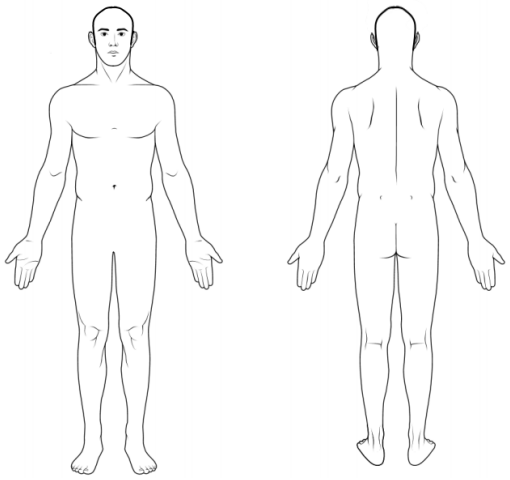
1st Body part: _____
Date symptom first appeared: _____
How often do you experience these symptoms?
◯ Constant 100% ◯ Frequent 75% ◯ Intermittent 50%
◯ Occasionally 25% ◯Rarely 10% or less
What makes the symptoms worse? _____
What makes the symptoms better? _____
Type of pain? ◯ Sharp ◯ Dull ◯Aching ◯ Burning
◯Throbbing ◯ Numb ◯ Other
Does the pain radiate? ◯ Yes ◯ No
If yes, to where? _____
Please rate the intensity of your pain on a scale of 1-10:
0 being no pain 10 being excruciating _____

Please mark areas of pain on the figure below



2nd Body part: _____
Date symptom first appeared: _____
How often do you experience these symptoms?
◯ Constant 100% ◯ Frequent 75% ◯ Intermittent 50%
◯ Occasionally 25% ◯Rarely 10% or less
What makes the symptoms worse? _____
What makes the symptoms better? _____
Type of pain? ◯ Sharp ◯ Dull ◯Aching ◯ Burning
◯Throbbing ◯ Numb ◯ Other
Does the pain radiate? ◯ Yes ◯ No
If yes, to where? _____
Please rate the intensity of your pain on a scale of 1-10:
0 being no pain 10 being excruciating _____

Please mark areas of pain on the figure below



3rd Body part: _____
Date symptom first appeared: _____
How often do you experience these symptoms?
◯ Constant 100% ◯ Frequent 75% ◯ Intermittent 50%
◯ Occasionally 25% ◯Rarely 10% or less
What makes the symptoms worse? _____
What makes the symptoms better? _____
Type of pain? ◯ Sharp ◯ Dull ◯Aching ◯ Burning
◯Throbbing ◯ Numb ◯ Other
Does the pain radiate? ◯ Yes ◯ No
If yes, to where? _____
Please rate the intensity of your pain on a scale of 1-10:
0 being no pain 10 being excruciating _____

Please mark areas of pain on the figure below