Dynamic Chiropractic LLC
720 E. Main St. Suite 1D
Moorestown, NJ 08057
856.222.1500

Today's Date: _____

Name_____ DOB: _____ Gender: M ☐ F ☐

Address_____

City _____ State _____ Zip Code _____

Cell Phone_____ Email _____

Occupation_____ Employer _____

Emergency Contact _____ Relation_____ Phone _____

Health Insurance:_____ Member ID: _____

Subscriber Name:_____ Subscriber DOB: _____

Height: _____ Feet:Inch Weight:_____ lbs

Why are you seeking chiropractic care:

_____

When / how did this start? _____

Does this interfere with your (circle) Sleep Work Daily Activities

On a scale from 1-10, 1 being no pain, rate your pain today? _____

What makes it better? _____ What makes it worse? _____

Describe your condition: (circle)

-Constant -Comes & Goes -Local -Radiating

-Numb/Tingling -Stabbing/Sharp -Burning -Ache -Stiff

Do you have difficulty: (circle)

Sitting Standing Bending Forward/Backwards Twisting

Lifting Walking Reaching overhead Other_____

Is this related to work or auto accidents? Y ☐ N ☐

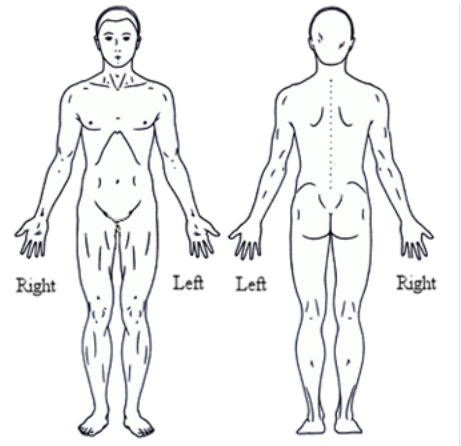
Are you in litigation for any accidents? (Auto, Worker's Comp, etc) Y ☐ N ☐

Is there anything else the Doctor or Staff should know?

_____

_____

Mark where you are experiencing symptoms



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Family History

Y N Diabetes
Y N High Blood Pressure
Y N Heart Disease
Y N Musculoskeletal Disease
Y N Cancer: _____
Y N Stroke/aneurysm
Y N Osteoporosis
Y N Other: _____

Current General History

Y N Unexplained Wt Change, Inc or Dec.
Y N Allergies: _____
Y N Bleeding/Bruising
Y N HIV
Y N Cancer: _____
Y N Insomnia
Y N Other: _____

Endocrine History

Y N Thyroid Condition: Hyper/Hypo
Y N Diabetes
Y N Other: _____

Eye/Ear/Nose/Throat

Y N Eye or Ear Pain
Y N Other Visual Conditions
Y N Change in vision/hearing/taste
Y N Ringing in Ears
Y N Dizziness
Y N Difficulty Chewing/Swallowing

Gastrointestinal System

Y N Anorexia/Bulimia
Y N Constipation/Diarrhea
Y N Nausea/Vomiting
Y N Abdominal Pain/Swelling
Y N Gallbladder Disease
Y N Liver/Pancreatic Disease:_____

Urinary System

Y N Urinary Urgency/Pain
Y N Difficulty holding/expelling
Y N Kidney Disease/Stone/Pain
Y N Prostate Issues
Y N Pelvic Pain

Cardiovascular System

Y N Heart Medications: _____
Y N Past heart or vascular disease
Y N Chest discomfort/pain
Y N Palpitations
Y N Edema
Y N High blood pressure
Y N Blood clot/aneurysm/DVT
Y N Sudden calf pain with walking
Y N Other: _____

Skin/Hair/Nails

Y N Skin Cancer
Y N Rashes/itching/lesions
Y N Psoriasis

Neurological System

Y N Headaches
Y N Seizures/epilepsy
Y N Vertigo
Y N Loss of sensation
Y N Head Trauma
Y N Multiple Sclerosis
Y N Vertebral Disc Condition
Y N Anxiety/Bipolar/Depression

Musculoskeletal System

Y N Osteoporosis/Fibromyalgia
Y N Arthritis: _____
Y N Scoliosis
Y N Joint pain/stiffness/swelling
Y N Muscle cramp/soreness/pain
Y N Neck pain
Y N Upper/Mid back pain
Y N Low back pain
Y N Shoulder/arm/hand pain
Y N Leg/knee/foot pain
Y N Fractures/dislocation/sprains
Y N TMJ issues

Pulmonary System

Y N Asthma/Shortness of Breath
Y N Apnea
Y N Pneumonia
Y N Cigarette Smoking
Y N Respiratory Infections
Y N Other: _____

Implants/Orthotics

Y N Cardiac/Pacemakers
Y N Joint replacement/Pins/plates/screws

Diet/Exercise

Y N Consume caffeine
Y N Consume alcohol

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List any surgeries/hospitalizations:

_____

_____

_____

List all current medications/supplements:

_____

_____

_____

Consent to Chiropractic Care

- I understand that my health records are the property of Dynamic Chiropractic LLC and will be protected under HIPAA. At any time, I have the right to request a copy of my health records which will have a fair material value fee to copy.
- I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled "Notice of Privacy Practices". I understand that I may review this notice at any time prior to signing this form.
- I authorize Dynamic Chiropractic to release information to any health care provider I am seeing and / or insurance company. I understand that any all payments are inherently my responsibility. I agree to my insurance company to be billed for payment and that I accept responsibility for what my insurance company may not cover. I agree to pay any balance associated with my care.
- I give my permission for my Doctor and/or staff to communicate by telephone or email regarding matters of chiropractic care, appointment reminders or scheduling.
- A parent must accompany his/her minor child on the first visit to Dynamic Chiropractic and sign a consent to treat minor for any additional visits where the Parent/Guardian will not be present.
- I authorize Dynamic Chiropractic to administer care as needed, as indicated from examination findings. Chiropractic adjustments are exceedingly safe when applied properly. However, I understand there are some risks to care including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to anticipate and explain every risk and complication, but I will rely on the doctor's best judgement to protect my best interests. No Guarantees of cure have been implied or given.
- The Doctor of Chiropractic will discuss any further risks inherent for my case. I understand that I am an active participant in my chiropractic care and that I am encouraged to bring up questions or express any concerns.
- Out of respect to the doctors as well as fellow patients in the office, if you need to reschedule or cancel an appointment, you can do so via our website. I acknowledge that if I do not call and do not show for my appointment there will be a $20 no-call no-show fee that will be applied to my account. Follow up visits will not be scheduled until the balance has been paid.
- I have reviewed and certify that all the information that I have reported above is true to the best of my knowledge and that I have read and understand the Consent to Chiropractic Care above.

_____ _____ _____ _____

Patient/Guardian's Signature Date Doctor Signature Date