momentum
CHIROPRACTIC HEALTH CENTER

Today's Date: _____

Whom may we thank for referring you to this office? _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone:_____

Do you have Insurance? ❑ Yes ❑ No

Employer: _____ Occupation: _____ Work Phone:_____

Marital Status: ❑ Single ❑ Married

Spouse's Name _____Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

On a scale of **0** to **10** with **TEN** being the worst pain and **ZERO** being no pain, rate your above complaints by ***circling the number*:**

Primary or chief complaint is : No Pain 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Worst

Second complaints is : No Pain 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Worst

Third complaint: : No Pain 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Worst

Fourth complaint: : No Pain 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Worst

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes

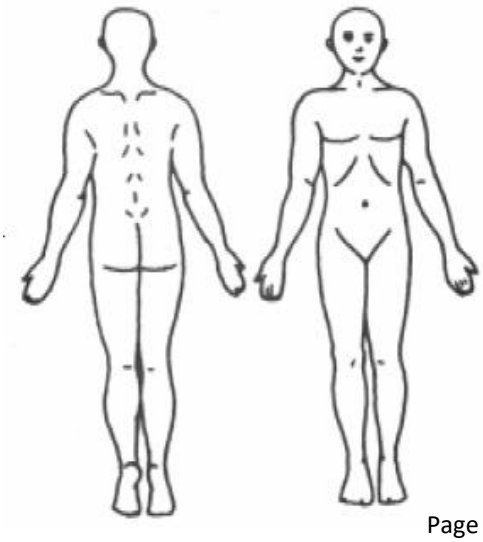
If **yes,** when: _____ by whom? _____

How long were you under care: _____

What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**

***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling



What relieves your symptoms? _____

What makes them feel worse? _____

Please check mark all the therapy options you would like to learn more about in our office:

____ Regenerative Medicine ____ PRP ____ Massage Therapy

____ REXO - Exosomes

____ Spinal Decompression ____ other

____ RESTOR - Cellular UmbilicalCord Tissue

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? _____
When was the last episode? _____
How did the injury happen? _____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment:
_____ Who provided it: _____ **How long ago?**_____
What were the results. ☐ Favorable ☐ Unfavorable→ please explain.

_____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ❑Cigars ❑ Pipe ❑ Cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. Alcoholic Beverage: → How Often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. Recreational Drug use: → How Often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following:

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	
_____:	_____	
_____:	_____	

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑ Grandmother ❑ Grandfather ❑ Mother ❑ Father ❑ Sister(s) ❑ Brother(s) ❑ Son(s) ❑ Daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

2. Any other hereditary conditions the doctor should be aware of? ❑ No ❑Yes: _____

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If you have ever been diagnosed or experienced any of the following conditions, please mark **P** for **Past,** **C** for **Currently** have and **N** for **Never**

___ Broken Bone	___Dislocations	___Cerebral Vascular	___Rheumatoid Arthritis	___ Fracture
___Disability	___Cancer	___ Heart Attack	___Osteo Arthritis	___ Diabetes
___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C

List Prescription & Non-Prescription drugs you take: _____

_____

_____

I hereby authorize payment to be made directly to MCHC for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to MCHC for any and all services I receive at this office.
I hereby acknowledge receiving a copy or been verbal informed of the practices 'Office Policies' and 'Patient Privacy Notice' documents, of which I have read and retained. This third page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies' as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____
Patient or Authorized Person's Signature

_____ - _____ - _____
Date Completed, Acknowledged and Accepted

_____
Patient's Name Print

_____
Doctor's Signature

___/___/___
Date Form Reviewed

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