APPLICATION FOR CARE AT MORAN SIGNATURE CHIROPRACTIC

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

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

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

Address: _____

City:_____State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____

Mobile Phone:_____ Work Phone: _____

Marital Status: □ Single □ Married Do you have Insurance: □ Yes □ No

Social Security #: _____Driver's License #: _____

Employer: _____ Occupation: _____

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:

Primary:

_____

Secondary:

_____

Third:

_____

Fourth:

_____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*:**

Primary or chief complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint is: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

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

How did the injury happen?

_____

Have your 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? _____

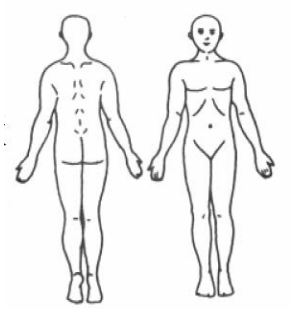
Name of Previous Chiropractor: _____ □ N/A

What relieves your symptoms?

_____

What makes your symptoms feel worse?

_____



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

LIST RESTRICTED ACTIVITY:	**CURRENT ACTIVITY**	**USUAL ACTIVITY**
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____
_____:	_____	_____

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

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PATIENT'S NAME: _____ HR#: _____ Date: _____

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?

_____

Have you tried any other forms of treatment?: □ No □ Yes

If yes, please state **what** type of treatment: _____

and 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:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past,*** **C** for ***Currently*** have or **N** for ***Never*** have had**:**

___ Broken Bone ___ Dislocations ___Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer

___ Heart Attack ___Osteoarthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions: _____

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: consumption occurs □ Daily □ Weekends □ Occasionally □ Never
3. Recreational Drug use: □ Daily □ Weekends □ Occasionally □ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect? (See ADL form)

FAMILY HISTORY:

PATIENT'S NAME: _____ HR#: _____ Date: _____

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: _____

I hereby authorize payment to be made directly to MORAN SIGNATURE CHIROPRACTIC, 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 MORAN SIGNATURE CHIROPRACTIC for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

PATIENT'S NAME: _____ HR#: _____ Date: _____

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

DATE _____

PLEASE PRINT YOUR NAME HERE _____

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climb Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer Use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lift Children/Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Read/Concentrate	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Getting Dressed	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Washing/Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other:_____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Please put a ✓ for in the **Past,** circle the word for **Currently** have, or leave blank for **Never**

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

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_____ _____-_____-_____

Patient or Authorized Person's Signature Date Completed

_____ _____-_____-_____

Doctor's Signature Date Form Reviewed

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name_____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache				Neck				Low Back		
No pain											**worst possible pain**
1	**2**	(**3**)	**4**	**5**	(**6**)	**7**	**8**	(**9**)	**10**		

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1 – What is your pain RIGHT NOW?

No pain										**worst possible pain**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

2 – What is your TYPICAL or AVERAGE pain?

No pain										**worst possible pain**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain										**worst possible pain**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain										**worst possible pain**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	

OTHER COMMENTS:

_____

_____ _____

_____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855 -862, 1993, with permission from Elsevier Science.

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Moran Signature Chiropractic have been explained to me to my satisfaction. I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ _____Witness Initials

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ _____Witness Initials

Patient or Authorized Person's Signature Date

FEMALES ONLY → please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on_____/____/_____

Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

_____ ____/____/____ _____Witness Initials

Patient or Authorized Person's Signature Date

MORAN SIGNATURE CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for thiscost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Drs. Antontious and Kimberly Moran at 404-682-6678. If they are unavailable, you may make an appointment with our receptionist to see he or she within 72 hours or 3 working days.

MORAN SIGNATURE CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of MORAN SIGNATURE CHIROPRACTIC Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____
Patient's Name DOB

_____ _____
Patient's Signature Date

_____ _____
Witness Date

Medical Information Release Form
(HIPAA Release Form)

Name:_____ Date of Birth: _____

Release of Information:

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:
[ ] Spouse_____ [ ] Child(ren) _____

[ ] Other_____ [ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.
Messages:
Please call [ ] my home [ ] my work [ ] my mobile number: _____
If unable to reach me:
[ ] you may leave a detailed message [ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (*day*)_____ between (*time*) _____

Signed:_____ Date: _____

Witness:_____ Date: _____