MORETTI CHIROPRACTIC

PREGNANCY, PEDIATRIC, & ADULT CARE

Today's Date: _____ SS # or Drivers License# _____

Name: _____ Nickname: _____

Date of Birth: _____/_____/_____ Age: _____ ☐ Male ☐ Female

Home Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work#: _____ Cell#': _____

E-mail address: _____

Your Occupation: _____ Your Employer: _____

Employer's Address: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Name of Spouse: _____

Do you have children? **Y** **N** Ages: _____ Names: _____

Emergency Contact: _____ Phone #: _____

Address: _____

* Who can we thank for referring you to our office? _____

The purpose of Chiropractic care is to remove vertebral subluxations to restore normal function to the nervous system and allow your body to express its optimum potential.

What is your reason for coming to our office? _____

_____

Did you have an injury? ____Yes ____No If Yes, please explain _____

_____

How long have you had this problem? _____

Type of pain: Sharp Dull Burning Throbbing Numbness Cramping Tight Radiating

Frequency of pain: Constant Intermittent

Does it interfere with: Work Sleep Walking Sitting Exercise Hobbies Leisure

Since it began, is it… About the same Getting Better Getting Worse Variable

What makes it better? _____

What makes it worse? _____

Is there a time of day that it is typically worse? Yes No If Yes, When? _____

Other doctors/treatments you've tried for this problem (Please List): _____

_____Chiropractor _____

_____Medical Doctor _____

_____Other _____

Have you seen a chiropractor before? **Y N** If so, who? _____

When was your last adjustment? _____ How long were you under care? _____

Have you ever been hospitalized? **Y N** If yes, explain: _____

Have you ever had surgery? **Y N** If yes, explain: _____

Body Signals: Please check any recurring symptoms you have, even if they do not seem related to your current problem(s).

- ❑ Headaches/Migraines
- ❑ Motion Restriction
- ❑ Pins & needles in legs
- ❑ Pins & needles in arms
- ❑ Nausea
- ❑ Dizziness
- ❑ Seizures
- ❑ Shortness of breath
- ❑ Cold sweats
- ❑ Hot flashes
- ❑ Reoccurring Infection
- ❑ Diabetes
- ❑ Memory Loss
- ❑ Back: Pain/Stiffness
- ❑ Neck: Pain/Stiffness
- ❑ Heartburn
- ❑ Arthritis
- ❑ Menstrual Cramping
- ❑ Menstrual Discomfort
- ❑ Menopause
- ❑ Ringing in ears
- ❑ Ear Infections
- ❑ Ulcers
- ❑ Diarrhea
- ❑ Kidney Problems
- ❑ Difficulty Urinating
- ❑ Problems Urinating
- ❑ Depression
- ❑ Infertility//Miscarriage
- ❑ High blood pressure
- ❑ Fainting
- ❑ Sinus Problems
- ❑ Allergies
- ❑ Anxiety
- ❑ Heart Attack/Stroke
- ❑ Jaw/TMJ Problems
- ❑ Constipation
- ❑ Numbness
- ❑ Asthma
- ❑ Difficulty Sleeping
- ❑ Frequent Urination
- ❑ Fatigue
- ❑ Joint(s): Paint/Stiffness

List any prescription medications you are currently taking:_____

_____

Lifestyle Questions: Please answer the following questions:

How much water, in ounces, do you drink on a daily basis? _____

Do you drink alcohol? **Y N** If so, how many drinks per week? _____

Do you smoke tobacco? **Y N** If so, how many packs per week? _____

Do you belong to a fitness club? **Y N**

Do you exercise? **Y N** How often & type of exercise: _____

Please list any sports you have played in the past:

_____

Please list any sports you currently play:

_____

Do you sit long hours at a desk? **Y N** If so, how many hours at a time? _____

Do you stand for long hours? **Y N** If so, how many hours at a time? _____

Do you regularly drive long hours? **Y N** If so, how many hours at a time? _____

Do you wear custom fit orthotics? **Y N** If so, approx. when did you purchase the orthotics? _____

On average, how many hours of sleep do you get per night? _____

Rate the quality of your sleep: Poor Fair Good Excellent

List any nutritional supplements/herbs you are currently taking: _____

_____

Please list any health or lifestyle goals you would like to achieve while under chiropractic care:

_____

_____

_____

_____

Pregnant Patients Only – Prenatal History: Please answer the following questions.

Name of Obstetrician/Midwife : _____ # of weeks: _____

Problems during Pregnancy: _____

Y N Experienced any physical trauma (falls or injuries)? _____

Y N Had any ultrasound studies or Doppler-tones? If so, how many?_____

Y N Eat a well-balanced diet? **Y N** Smoke tobacco? **Y N** Drink alcohol?

Y N Take any drugs or medications? _____

Y N Had any emotional trauma or difficulty?_____

Y N Exercise? _____

If you are in the third trimester, what is the presentation of baby? (circle one) Vertex Breech Transverse Face/Brow

Pregnant Patients Only – Previous Births: Please answer the following questions regarding previous births.

Third trimester presentation (circle one): Vertex Breech Transverse Face/Brow

Type of Birth (circle one): Normal Vaginal Forceps Cesarean Suction Cap/Vacuum

Location (circle one): Home Birthing Center Hospital

Problems during pregnancy: _____

Problems during labor/delivery: _____

For Women Only – Pregnancy Release:

Are you pregnant? Yes No Due Date:_____

This is to certify that to the best of my knowledge I am not pregnant and the doctors and staff of Moretti Chiropractic have my permission to perform an x-ray evaluation, if needed. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Print Name:_____

Signature:_____ Date: _____

PLEASE READ AND SIGN THE STATEMENT BELOW:

PAYMENT AND INSURANCE INFORMATION

If you are here because you have been involved in an accident (automobile, personal or work-related) please notify us immediately and fill out an additional accident information form.

PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH OUR OFFICE

I, _____ am responsible for payment and I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. I clearly understand and agree that all services rendered to me by Moretti Chiropractic are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature _____ Date _____

Relationship to patient (CIRCLE ONE): SELF SPOUSE PARENT GUARDIAN

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. In the course of your care as a patient at Moretti Chiropractic, we may use or disclose personal and health related information about you in the following ways:
A. Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

B. Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

We are permitted and may use or disclose your protected health information without your written consent, written authorization or oral agreement under the following circumstances:

- ❑ If we provide services to you in an emergency treatment situation.
- ❑ If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.
- ❑ If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat you.
- ❑ If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care of your location, general condition, or death.
- ❑ If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.
- ❑ If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse, neglect, or domestic violence.
- ❑ If we are required to disclose your health information to the Food and Drug Administration.
- ❑ If we are required to disclose your health information in response to a court order or a subpoena or a law enforcement official.
- ❑ If we are required to disclose your health information to a coroner, medical examiner or funeral director.
- ❑ If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.
- ❑ I understand Moretti Chiropractic may use my name, address, phone number, and email to contact me with birthday cards, holiday related cards and announcements regarding patient appreciation days and/or other special occasions, and information about treatment alternatives or other health related information. I am also aware that on specific occasions photographs may be taken and posted within the office or placed on our website or Facebook page for others to see.
- ❑ If I have given, or will give in the future, a written testimony as to my health care with Moretti Chiropractic, I give permission to share this information in whatever manner they deem appropriate.
- ❑ If photos and/or videos of me are taken, I give my permission for these to be used by *Dr. Moses Moretti and Moretti Chiropractic* for educational or marketing purposes, and release *Dr. Moses Moretti and Moretti Chiropractic* and any third party producers of said materials from any legal claims or liability arising from the use of said materials. I may contact Moretti Chiropractic if I wish to withdraw my consent.

Signature _____ Relationship to Patient_____
Patient or Personal Representative/Guardian

Print Name _____ Date _____
Patient Name