TEXAS Chiropractic College

MOODY HEALTH CENTER

Welcome to the Moody Health Center at Texas Chiropractic College! We are happy you have chosen us for your healthcare needs.

Before we get started, please provide us with some information about yourself and why you're here. If you have any questions about these forms, just ask!

Patient Information:

Last Name First Name Middle Initial

Address

City State Zip Code Phone

Social Security Number Email

Date of Last Physical *(MM/DD/YYYY)* Date of Birth *(MM/DD/YYYY)* Age

Gender: ☐ Male ☐ Female ☐ Trans Male ☐ Trans Female ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced # of Children_____

Occupation: _____ Employer: _____

Are you a student at Texas Chiropractic College, or related to a student at this college? ☐ Yes ☐ No

Are you: ☐ TCC Staff/Faculty? ☐ TCC Alumni? ☐ Chiropractor? ☐ Active DOD?

(Please leave blank if N/A)

Who may we thank for referring you, or, how did you hear about us?

I hereby affirm that the information I have provided above is both accurate and truthful:

Patient signature (Guardian signature if patient is a minor) ***Date***

Form Revised Dec. 2015

Now we'd like to find out more about why you're here. Please take time to complete this section thoroughly – doing so allows us to know more about you, and this gives us an opportunity to provide you with the best care possible.

Please describe the reason for your visit:

Are you currently under care for this problem(s)? ☐ Yes ☐ No

If yes, please provide the doctor/therapist's name: _____

Are you taking any medications (for any reason)? ☐ Yes ☐ No

If so, please list:

Past Medical History

In order to provide you with the best care possible, we need to know as much as possible about your past medical history. *Please look over the lists below, and place a check mark next to any condition, symptom, or illness that you have **NOW** or have ever had in the **PAST**.*

- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Hyper- or Hypotension
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Multiple Sclerosis
- ☐ Neurological Disease
- ☐ Fractures
- ☐ Spinal/Head Injury
- ☐ Osteoporosis
- ☐ STD
- ☐ Bleeding Disorder
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ GI Disorders
- ☐ Anorexia/Bulimia
- ☐ Depression
- ☐ Anxiety/Panic Attack
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Sinus Trouble
- ☐ Allergies
- ☐ Asthma
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Ulcers
- ☐ Hernia
- ☐ Thyroid Disease
- ☐ Gout
- ☐ Typhoid Fever
- ☐ Scarlet Fever
- ☐ Rheumatic Fever
- ☐ Measles/Mumps
- ☐ Mononucleosis
- ☐ Trouble sleeping
- ☐ Nervousness
- ☐ Dizziness/Vertigo
- ☐ Unexplained weight loss
- ☐ Fatigue
- ☐ Night sweats
- ☐ Nausea
- ☐ Unexplained Fever
- ☐ Excessive hunger/thirst
- ☐ Bowel problems
- ☐ Urination problems
- ☐ Sexual dysfunction
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Vision problems
- ☐ Cold hands/feet
- ☐ Ringing in ear(s)
- ☐ Persistent cough
- ☐ Bruise easily
- ☐ Back pain
- ☐ Herniated disk
- ☐ Numbness in arm or leg
- ☐ Pain in arm or leg
- ☐ Headache
- ☐ Pinched nerve
- ☐ Tension/stiffness
- ☐ Weakness

WOMEN ONLY:

- ☐ Breast lump
- ☐ Menstrual pain
- ☐ Abnormal bleeding
- ☐ Vaginal Discharge
- ☐ Nipple Discharge
- ☐ Painful intercourse

MEN ONLY:

- ☐ Penis discharge
- ☐ Testicular lump
- ☐ Prostate Disease

Patient Background Information Continued:

Have you ever seen a chiropractor before today? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how many packs a day? _____ For how many years? _____

Do you drink? ☐ Yes ☐ No If yes, amount: _____

Have you had x-rays taken of:	*Yes*	*No*
Low Back	☐	☐
Neck	☐	☐
Chest	☐	☐
Other *(describe below)*	☐	☐

_____

Are you pregnant? ☐ ☐

Are you interested in learning about exercise, nutrition, or other wellness topics? ☐ Yes ☐ No

If yes, please specify: _____

Are there any questions you'd like to have answered about chiropractic care? _____

_____

Education Level

- ☐ Grade 8 or less
- ☐ Partial High School
- ☐ High School Graduate
- ☐ Some College
- ☐ College Graduate
- ☐ Masters or Higher

Employment Status

- ☐ Paid Full Time
- ☐ Paid Part Time
- ☐ Homemaker
- ☐ Student
- ☐ Unemployed
- ☐ Retired

Main Work Activity

- ☐ Heavy Labor
- ☐ Light Labor
- ☐ Mostly Sitting at Desk
- ☐ Mostly Standing
- ☐ Walking/Moving About
- ☐ Driving/Operating Vehicle

Job Satisfaction

- ☐ Really Like My Job
- ☐ Like My Job
- ☐ No Opinion
- ☐ Dislike My Job
- ☐ Really Dislike My Job

_____

If your injury is accidental, please complete the following questions:

Date of accident: _____ Time: _____ Location: _____

How did accident occur? On-the-job? ☐ Yes ☐ No Auto accident? ☐ Yes ☐ No Other (describe) _____

Do you have an attorney advising in this case? ☐ Yes ☐ No Has a report been filed? ☐ Yes ☐ No

Insurance Information

(If you are a cash patient, you make skip this page)

We are providers for most area healthcare insurance companies. If you would like us to submit charges for care to your health insurance carrier, please provide your insurance card to our Reception Desk so that we may make a copy for our file; in addition, please sign the ***Assignment of Benefits*** below.

We will notify you about your health plan's specific benefits before you leave. Thank you!

Assignment of Benefits:

I, the undersigned, have health insurance coverage with (Insurance Co. name) _____.

I assign all medical benefits directly to Moody Health Center for services rendered herein. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize release of my healthcare information to secure the payment of benefits, as necessary. I authorize the use of this signature on all insurance submissions:

_____

Signature of Insured/Guardian Date

If you are seeing us because of an auto or work-related accident, please fill out the following areas on this page identified specifically for these situations. If not, please ignore these areas.

For Auto Accidents:

Insurance company: _____

_____

Address City State Zip Code

_____

Claim Number (if known) Claims Representative Telephone Number

For Work-Related Accidents:

Employer: _____

_____

Address City State Zip Code

Supervisor's name/telephone: _____

Has your employer been notified about your injury? ☐ Yes ☐ No

_____

Claim Number (if known) Claims Representative Telephone Number

You're almost done...

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (your name, printed) acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Moody Health Center, which describes policies and procedures regarding the use and disclosure of any or all of my personal protected health information that has been created, received, or maintained by Moody Health Center and/or its representatives

_____

Signature Print Name Date

Contacting you and others

May we call you about appointments, lab and x-ray results, and other health care information? ☐ Y ☐ N

May we leave messages for you regarding this information? ☐ Y ☐ N

If not, is there an alternative method for contacting you about this information? ☐ Y ☐ N

Preferred method of communication: _____

Please provide is with an emergency contact person:

_____

Name Relationship to You Phone Number

Thank you. We're ready to get started!

Please save this PDF to your computer and email it as an attachment to MoodyHealth@txchiro.edu so we may have your patient file prepared for your first appointment. If you are emailing the forms, you will be asked to sign them upon arrival at MHC. You may also print this document and bring it with you for your appointment.

If you have any problems, please call us at 281-487-1501.
We look forward to working with you!