**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 are here. If you have any questions about these forms please ask!**

## Patient Information:

Last Name First Name Middle Initial

Address

City State Zip Code Phone Number

Social Security Number Email Address

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

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:

Now we would 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? Yes ☐ No ☐

If so, please list: ____________________________________________

**PAST MEDICAL HISTORY:**
In order to provide you with the best care, 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 | | Anorexia/Bulimia | | Trouble sleeping | | Back pain |
| | Pacemaker | | Depression | | Nervousness | | Herniated disk |
| | Stroke | | Anxiety/Panic attack | | Dizziness/Vertigo | | Numbness in arm or leg |
| | Vascular disease | | Tuberculosis | | Unexplained weight loss | | Pain in arm or leg |
| | Hyper -or- Hyptension | | Emphysema | | Fatigue | | Headache |
| | Cancer | | Sinus trouble | | Night sweats | | Pinched nerve |
| | HIV/AIDS | | Allergies | | Nausea | | Tension/stiffness |
| | Multiple sclerosis | | Asthma | | Unexplained Fever | | Weakness |
| | Neurological disease | | Kidney disease | | Excessive hunger/thirst | | **WOMEN ONLY:** |
| | Fractures | | Liver disease | | Bowel problems | | Breast lump |
| | Spinal/Head Injury | | Ulcers | | Urination problems | | Menstrual pain |
| | Osteoporosis | | Hernia | | Sexual dysfunctioin | | Abnormal bleeding |
| | STD | | Thyroid Disease | | Chest pain | | Vaginal discharge |
| | Bleeding disorder | | Gout | | Heart palpitations | | Nipple discharge |
| | Diabetes | | Thyphoid Fever | | Vision problems | | Painful intercourse |
| | Epilepsy | | Scarlet Fever | | Cold hands/feet | | **MEN ONLY:** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Arthritis | | Rheumatic Fever | | Ringing in ear(s) | | Penis discharge |
| | Rheumatoid Arthritis | | Measles/Mumps | | Persistent cough | | Testicular lump |
| | GI disorders | | Mononucleosis | | Bruise easily | | 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) ______________________________________________________________

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 | | Employment Status | | Main Work Activity | | Job Satisfaction |
|---|---|---|---|---|---|---|---|
| | Grade 8 or less | | Paid Full Time | | Heavy Labor | | Really Like My Job |
| | Partial high School | | Paid Part Time | | Light Labor | | Like My Job |
| | High School Graduate | | Homemaker | | Mostly Sitting at Desk | | No Opinion |
| | Some College | | Student | | Mostly Standing | | Dislike My Job |
| | College Graduate | | Unemployed | | Walking/Moving About | | Really Dislike My Job |
| | Masters or Higher | | Retired | | Driving/Operating Vehicle | | |

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

Date of accident: ___________________Time: ______________ Location: _____________________________________

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

_______________________________________________________________________________________________

_______________________________________________________________________________________________

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

**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-Relate 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

## Insurance Information

(If you are a cash patient, you may skip this section)

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 files; 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

# You're almost done…

Acknowledgement of Receipt 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? ☐ Yes ☐ No

May we leave messages for you regarding this information? ☐ Yes ☐ No

If not, is there an alternative method for contacting you about this information? ☐ Yes ☐ No

Preferred method of communication: ____________________________________________________

Please provide us 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, print and bring it with you to your appointment.

If you have any problems, please call us at (281)281-487-1501

We look forward to working with you!