PATIENT HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____

WELCOME: The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

PERSONAL INFORMATION:

Name: _____ Date of Birth: _____ Age _____
Address _____ City_____ State _____ Zip_____
Marital Status (*x*): Divorced Married Single Separated Widowed
Gender (x): Male / Female Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____
Social Security #: _____-_____-_____ email _____@_____
Spouses Name: _____

Emergency Contact Information
Name: _____ Jr., II, III, IV
Address: _____ City: _____ State: _____ Zip: _____
Relationship: _____ Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

PAYMENT/INSURANCE INFORMATION:

Is the condition(s) that brought you here today due to an automobile accident or on the job injury?
□ Yes □ No
Who besides yourself is responsible for your bill? □Self-Pay □Health Insurance □ Worker's Comp
□Auto Insurance □ Other (*Be Specific*): _____
Personal Health Insurance Carrier: _____ Health ID Card #:_____
Insured Person's Name: _____ Group #: _____
Insured Person's Date of Birth: _____ /_____/_____
Insured Person's Social Security #: _____-_____-_____
Auto or Workers' Comp Insurance Carrier & Claim #: _____

PRIMARY COMPLAINT:

_____
When did it start? _____
Describe the condition:_____
What do you think caused the problem?_____
Rate the pain from 1-10: At it's worst ____ At the present time ___ At least severe ___
Does the pain travel? □ Yes □ No If yes, from where to where? _____
Is condition getting worse? □ Yes □ No
List the activities that this condition prevents you from doing? _____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:

I authorize payment of medical benefits to In Motion Chiropractic, PC, Dr. Darren Mollo for services rendered to me.

ACCEPTANCE AS A PATIENT:

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment if I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information
gathering so that the doctor can determine whether to accept me as a patient.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

TO THE PATIENT: You have a right to be informed about your condition, the recommended chiropractic treatment, and benefits and risk of treatment. This information will assist you in making an informed decision. As with all forms of treatment from taking an over the counter medication, receiving massage therapy or exercise therapy, to medical treatment and invasive procedures and even doing nothing at all, your choice carries benefits and risks.

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of rehabilitative therapy. The chiropractic treatment may be performed by In Motion Chiropractic, P.C. and the Doctor of Chiropractic, Dr. Darren T. Mollo, and/or licensed Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic.

I understand that, there are some risks to chiropractic treatment including, but not limited to, sprains, strains, dislocations, fractures, aggravation of condition, no improvement, and burns or frost bite from rehabilitative therapy. In extremely remote cases there have been reported complications of vertebra-vascular injury (stroke) when a patient receives a cervical adjustment.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

Name: _____

Patient's Representative/ Interpreter: _____

_____

Signature: _____

Date: _____

Relation: _____

Doctor signature: _____

Rep./ Interpreter signature: _____