William E. Moody, DC, CPT
2909 Reynolda Road, Winston-Salem, NC 27106
P 336-777-8450 F 336-777-8435

Confidential Patient Information

Name _____ Date _____

Address Street_____City_____State_____Zip_____

Birth Date ____ / ____ / _____ Age _____ Marital Status *S M W D* Children _____

Social Security No (optional) _____ Employer _____

Work Address _____ Occupation _____

Name of Spouse _____ Employer_____

Primary Physician _____ Practice Name_____

Practice Phone _____ Who referred you to our office? _____

List present complaints/injuries and duration.

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____

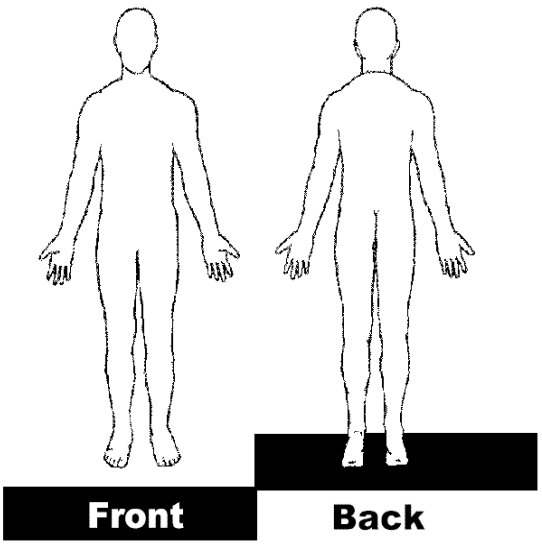
Symptoms are:
( ) getting worse ( ) getting better ( ) unchanging

List any doctors consulted for present complaints:

Name _____
Practice Name _____
Address _____
Date(s) Seen _____

Name _____
Practice Name _____
Address _____
Date(s) Seen _____

Mark areas of pain on the figures below:



0 ---------- 5 ---------- 10

Circle your pain. 0 = none, 10 = unbearable

Please circle current conditions, check former conditions, and give details on marked conditions at the bottom of the page

General
- ❑ Allergies
- ❑ Arm pain/numbness
- ❑ Leg pain/numbness
- ❑ Headache
- ❑ Fever
- ❑ Chills
- ❑ Sweats
- ❑ Fainting
- ❑ Dizziness
- ❑ Convulsions
- ❑ Loss of sleep
- ❑ Fatigue
- ❑ Nervousness
- ❑ Weight gain/loss
- ❑ Allergy
- ❑ Wheezing
- ❑ Neuralgia/neuritis
- ❑ Depression
- ❑ Masses

Ear, Eye, Nose, Throat
- ❑ Near-sightedness
- ❑ Far-sightedness
- ❑ Crossed eyes
- ❑ Eye pain
- ❑ Deafness
- ❑ Tinnitus
- ❑ Earache
- ❑ Ear Discharge
- ❑ Nose Bleeds
- ❑ Nasal Obstruction
- ❑ Sore Throat
- ❑ Hoarseness
- ❑ Asthma
- ❑ Gum Trouble
- ❑ Frequent Colds
- ❑ Enlarged Thyroid
- ❑ Tonsillitis
- ❑ Sinus Infection
- ❑ Nasal Drainage
- ❑ Enlarged Glands

Skin
- ❑ Skin Eruptions
- ❑ Itching
- ❑ Easy bruising
- ❑ Dryness
- ❑ Boils
- ❑ Varicose veins
- ❑ Sensitive skin
- ❑ Hive or allergy

Respiratory
- ❑ Chronic Cough
- ❑ Spitting up phlegm
- ❑ Spitting up blood
- ❑ Chest Pain
- ❑ Difficulty breathing

Cardiovascular
- ❑ Rapid heartbeat
- ❑ Slow heartbeat
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pain over heart
- ❑ Previous heart attack
- ❑ Hardening of arteries
- ❑ Poor circulation
- ❑ Paralytic stroke
- ❑ Aneurysm

Muscle and Joint
- ❑ Arthritis
- ❑ Stiff neck
- ❑ Backache
- ❑ Swollen joints
- ❑ Painful tailbone
- ❑ Pain in shoulders
- ❑ Hernia
- ❑ Spinal curvature
- ❑ Faulty posture

Genitourinary
- ❑ Frequent urination
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Pus in urine
- ❑ Kidney infection
- ❑ Kidney stones
- ❑ Bed wetting
- ❑ Prostate problems
- ❑ Inability to control urine

Gastrointestinal
- ❑ Poor appetite
- ❑ Difficult digestion
- ❑ Excessive hunger
- ❑ Belching or gas
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Pain over stomach
- ❑ Constipation
- ❑ Colon trouble
- ❑ Hemorrhoids
- ❑ Intestinal parasite
- ❑ Liver trouble
- ❑ Gallbladder trouble
- ❑ Jaundice
- ❑ Colitis

Female
- ❑ Painful menstruation
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Cramps/backache
- ❑ Previous miscarriage
- ❑ Vaginal discharge
- ❑ Lumps in breast
- ❑ Menopausal symptoms
- ❑ Pregnancy

Diseases/Disorders
- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anemia
- ❑ Aneurism
- ❑ Appendicitis
- ❑ Asthma
- ❑ Cancer
- ❑ Chicken pox
- ❑ Diabetes
- ❑ Diphtheria
- ❑ Drug dependency
- ❑ Eczema
- ❑ Emphysema
- ❑ Endometriosis
- ❑ Epilepsy
- ❑ Heart disease
- ❑ Influenza
- ❑ Iron deficiency
- ❑ Irritable bowel
- ❑ Juvenile arthritis
- ❑ Juvenile diabetes
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Malaria
- ❑ Malignancy
- ❑ Measles
- ❑ Mental disorder
- ❑ Mumps
- ❑ Neurofibromatosis
- ❑ Pleurisy
- ❑ Pneumonia
- ❑ Polio
- ❑ Rheumatic fever
- ❑ Rubella
- ❑ Scarlet fever
- ❑ Small pox
- ❑ Spinal stenosis
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ Typhoid fever
- ❑ Whooping cough
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

Coffee, tea, caffeinated soft drinks (cups per day) _____
Tobacco (packs per day) _____
Permanent Disability Rating _____% Location _____ Since ___/___/____

Past Health History
List surgeries, broken bones, emergency room visits and years of occurrence:
_____
List accidents, injuries, and falls (auto, work, home, leisure):
_____
List medications and/or diet supplements:
_____

X-ray Confirmation: I understand that X-rays can be hazardous to an unborn child. At this time, I certify that I am not pregnant and I consent to radiographic examination if found to be medically necessary.
Signed: _____

Consent to treat a minor child: I hereby authorize this office to administer chiropractic treatment as deemed necessary to my child.
Signed: **_____ (Parent / Legal Guardian)**

Contact Information
Please provide contact information so that we may reach you regarding scheduling, patient care, and billing:

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, **I understand** that this chiropractic office may prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. **I clearly understand and agree** that all services rendered to me 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 me will be immediately due and payable. **I agree** that all telephone numbers provided may be subject to receiving telephone calls from an automated dialer using a pre-recorded, artificial voice message or a live operator call. I give my prior express consent to receive such phone calls, including any calls made to my provided cellular telephone number.

Patient's Signature _____ Date _____

Please provide emergency contact information so that we may reach a person to act on your behalf in the event of an emergency:

Name: _____

Relationship: _____

Phone Number: _____

Dynamic Motion Chiropractic
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Consent for Use or Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we will always respect the privacy or your health information. There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Uses or Disclosures

- You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations.
- If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing.
- We are not required to agree to your restrictions. However, if we agree with your restrictions, that restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read this consent policy and agree to its terms.

_____	_____
Printed Name	Provider Representative
_____	_____
Signature	Date
_____	
Date	

Dynamic Motion CHIROPRACTIC
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Automobile Accident Information

1. Accident Date: _____ Time of accident: _____ □ am □ pm
2. Location: Intersection _____ City, State _____
3. What were the weather conditions?
   □ dry □ wet □ raining □ snowing □ ice
4. How many vehicles were involved in the accident? _____
5. What was the estimated damage to the vehicle you were in? (in dollars) _____
6. How was your vehicle impacted?
   □ rear-ended □ hit on drivers side □ hit on passenger side □ hit another vehicle
7. Did your vehicle hit anything after the accident? □ no □ yes (describe)_____
8. What type of vehicle were you in? Make and model if known _____
   □ compact car □mid-size car □ full size car □ truck
   □ SUV □ minivan □ van □ other_____
9. What type of vehicle impacted yours? Make and model if known _____
   □ compact car □ mid-size car □ full size car □ truck
   □ SUV □ minivan □ van □ other_____
10. Where were you sitting in your vehicle during the accident?
    □ driver □ front passenger □ rear left passenger □ rear right passenger
11. At the time of the impact, how fast was your vehicle moving? _____ MPH
    □ slowing down □ stopped □ gaining speed □ moving steady speed
12. Did you know the accident was coming?
    □ unaware of collision □ aware of collision but relaxed □ aware of collision and braced
13. Did you lose consciousness during the accident? □ yes □ no
14. Did you have your seatbelt on during the accident? □ yes □ no
15. Did your airbag deploy? □ yes □ no
16. Did you go to the hospital? □ yes □ no. If no, why _____(skip 17-20)
17. How did you get to the hospital?
    □ ambulance □ drove self □ friend drove □ walked □ helicopter □ police car □ other
18. What was the name of the hospital? _____ Were you hospitalized overnight? □ yes □ no
19. Were □ X-rays or □ MRIs taken at the hospital?
    □ Skull □ Neck □ Mid-Back □ Lower-Back □ Pelvis □ Hips
    □ Thigh □ Knee □ Foot/Ankle □ Shoulder □ Arm □ Wrist/Hand
20. Check what you have been prescribed for your injuries:
    □ pain medication □ muscle relaxers □ neck brace □back brace
21. Which of these daily activities have been affected?
    □ work duties □ grooming □ dressing □ cooking
    □ house work □ walking □ sitting □ other

Patient Signature: _____ Date:_____