

Moua-Lor Chiropractic & Acupuncture, P.A.

1819 Lowry Ave North, Minneapolis, MN 55411/ 616 Rice Street Suite B, Saint Paul, MN 55103

Phone: (612) 529-0202 Fax: (612) 521-1445/ Phone: (651) 224-9400 Fax: (651) 224-0690

PLEASE PRINT:

DATE: ____/____/____

NAME (First, middle, last): _____ Email: _____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

SEX: FEMALE MALE

CELL PHONE: (____) _____

BIRTHDATE: ____/____/____

HOME PHONE: (____) _____

SOCIAL SECURITY NO: ____-____-____

WORK PHONE: (____) _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SEPERATED

EMPLOYMENT STATUS: EMPLOYED UNEMPLOYED RETIRED HOMEMAKER
 FULL-TIME STUDENT PART-TIME STUDENT

EMERGENCY CONTACT INFORMATION:

(First, Middle, Last Name) (Phone Number) (Relationship to Patient)

EMPLOYMENT INFORMATION:

(Work Title) (Company Name)

(Company Address) (City, State, Zip Code)

HISTORY OF PRESENT ILLNESS/INJURY: Other _____ Work Injury Date: ____/____/____

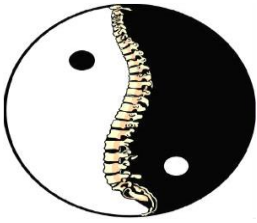
Car Collision Date: ____/____/____

(Name of Insured in Car Policy) (Date of Birth) (Relationship to Patient)

(Car or WC Insurance Company Name) (Car or WC Claim Number)

Medical card(s) (make copy): _____
(Name of medical insurance card(s))

Do you have **Medicare**? (card with blue and red line) (make copy): No Yes



Moua-Lor Chiropractic & Acupuncture, P.A.

1819 Lowry Ave North, Minneapolis, MN 55411/ 616 Rice St Suite B, Saint Paul, MN 55106
Phone: (612) 529-0202 Fax: (612) 521-1445/ Phone: (651) 224-9400 Fax: (651) 224-0690

Patient name: _____ DOB: _____ Date of Injury: _____

CHIEF COMPLAINTS:

Where are you hurting? _____

Accident description? _____

Pain scale: (circle your pain)



No Pain
(0)



Mild Pain
(1-3)



Moderate Pain
(4-5)



Severe Pain
(6-7)



Very Severe Pain
(8-9)



Worst Possible Pain
(10)

Please describe your pain:

Circle your pain: constant, comes and goes, getting better/worse, or staying the same.

Circle your pain: dull aching, sharp, stiff, stabbing, burning, tight, inflamed, numbness or tingling.

What makes the condition better?

- Take prescribed medications
- Massage
- Take OTC (over-the-counter) medications
- Other: _____

What makes the condition worse?

- Standing
- Sitting
- Lying
- Other _____
- Bending
- Lifting
- Twisting

PAST MEDICAL HISTORY:

1. Have you ever seen a chiropractor before? No Yes If yes, when? _____

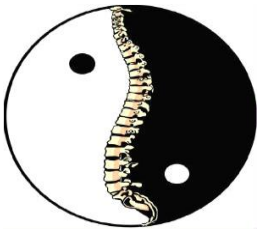
Doctor's name and location? _____

For what reason? _____

2. Have you been in a car accident in the past? No Yes If yes, when? _____

Was anything injured? No Yes If yes, what? _____

How was it treated? _____



Moua-Lor Chiropractic & Acupuncture, P.A.

1819 Lowry Ave North, Minneapolis, MN 55411/ 616 Rice St suite B, Saint Paul, MN 55103
Phone: (612) 529-0202 Fax: (612) 521-1445/ Phone: (651) 224-9400 Fax: (651) 224-0690

Patient name: _____ DOB: _____ DOI: _____

PAST MEDICAL HISTORY (cont.):

- 3. A.) Do you have a family doctor? No Yes
- B.) Doctor's name/clinic and address? _____
- C.) Have you seen a medical doctor for this condition? No Yes If yes, when? _____
- D.) Doctor's name/clinic and address? _____
- E.) Do you see your doctor for any other conditions? (Diabetes, high blood pressure, high cholesterol, other):
- F.) Do you take any prescribed medication for your current condition or other conditions? No Yes
- G.) Please list prescribed medication you are currently taking: _____
- H.) Have you had any surgery in the past? No Yes If Yes for what: _____
- 4. Have you been hospitalized in the past? No Yes If yes, when? _____
- Hospital name and address? _____
- Reason for hospitalization? _____
- 5. Allergies? No Yes If yes, explain _____
- 6. Do you have any broken bones? No Yes If yes, where? _____

SOCIAL HEALTH HISTORY:

- 7. Are you a smoker? No Yes If so, how many per a day? _____
- 8. Do you consume caffeine? No Yes If so, how much per day? _____
- 9. Do you consume alcohol? No Yes If so, how many glasses per day? _____
- 10. Do you exercise? No Yes If yes, what? _____
- 11. **FOR FEMALE PATIENTS ONLY:**
- Are you pregnant or is there any possibility that you may be pregnant? No Yes
- If so, how many days, weeks, or months? _____

FAMILY HEALTH HISTORY:

Health Status: (If deceased, from what?) _____

Father: _____

Mother: _____

Sisters: _____ How many? _____

Brothers: _____ How many? _____

Children: _____ How many? _____

(Patient or other legally authorized person signature)

_____/_____/_____
(Date)