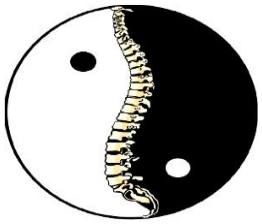

Moua-Lor Chiropractic & Acupuncture, P.A.
1819 Lowry Ave North, Minneapolis, MN 55411
Phone: (612) 529-0202 Fax: (612) 521-1445

PLEASE PRINT: DATE: _____/_____/_____

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

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

SEX: ☐ FEMALE ☐ MALE

CELL PHONE: (_____) _____

BIRTHDATE: _____/_____/_____ HOME PHONE: (_____) _____

WORK PHONE: (_____) _____

SOCIAL SECURITY NO: _____-_____-_____

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

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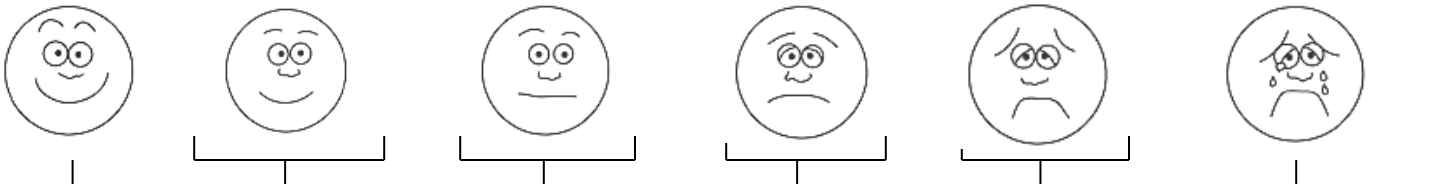
Patient name: _____DOB: _____Date of Injury: _____

CHIEF COMPLAINTS:
Check where you are hurting:

- ☐ Headaches
- ☐ Dizziness
- ☐ Neck
- ☐ Upper Back
- ☐ Mid-Back
- ☐ Lower Back
- ☐ L/R Shoulder
- ☐ L/R Ankle
- ☐ L/R Arm
- ☐ L/R Leg
- ☐ L/R Knee
- ☐ Chest wall
- ☐ Others: _____ _____ _____

Accident Description? (Circle)
Rear-ended Front impact Side Impact

Pain scale: (circle your pain)



No Pain | Mild Pain | Moderate Pain | Severe Pain | Very Severe Pain | Worst Possible Pain

Please describe your pain:

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

Circle your pain feeling: 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 ☐ Bending
- ☐ Sitting ☐ Lifting
- ☐ Lying ☐ Twisting
- ☐ Other _____

Any loss of bladder/bowel control? Yes or No

Any activities that make your pain worse?
_____

PAST MEDICAL HISTORY:

1. Have you ever seen a chiropractor before? ☐ No ☐ Yes If yes, when? _____
   Doctor's name and location? _____
   _____
2. Have you been in a car accident in the past? ☐ No ☐ Yes If yes, when? _____
   Was anything injured? ☐ No ☐ Yes If yes, what? _____

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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.) Do you have Hepatitis B (mob kab siab B) or Tuberculosis (TB) (mob ntsws qhuav)? _____
4. Have you been hospitalized or had surgery 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)