

Welcome to our office!

Mooney Chiropractic

Patient Information

Full Legal Name: _____ Nick Name: _____
First Name Middle Initial Last Name

Home Address: _____
Street City State Zip

Home Phone: (____) _____ E-Mail: _____ Cell Phone: (____) _____

Sex: Male Female Marital Status: Single Married Divorced Widowed Separated Birth Date: ____/____/____

Social Security #: _____ Occupation: _____ Employer: _____

Employer Address: _____
Street City State Zip

Work Phone: (____) _____ Ext: _____ Fax: (____) _____ E-Mail: _____

How did you find out about our office? Friend/Family Insurance Attorney MD Internet Phone Book Ad Other: _____

Who may we thank for referring you? _____

Insurance Information

Insurance Company: _____ Ins.Phone #: (____) _____

Relationship to Insured: Self Spouse Child Other (If "self", you may skip the rest of this section)

Insured's Name: _____ Insured's Date of Birth: ____/____/____
First Name Middle Initial Last Name

Insured's Social Security #: _____ Employer: _____

Insured's Address (if different): _____
Street City State Zip

Account Information

Payment Method: CASH CHECK CREDIT CARD GIFT CERTIFICATE CONSULT ONLY

Driver's License #: _____ State: _____ Exp: _____

CC #: _____ VISA M/C Exp. ____/____ Cardholder: _____

I hereby authorize payment of any unpaid co-insurance, co-payment, or deductible to be applied to the above credit card.

In Event of Emergency

Who should we contact? _____ Relation: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Nearest Relative: _____ Phone: (____) _____ Relation: _____

Nearest Friend: _____ Phone: (____) _____

- I hereby certify that the information provided on this form is true and correct.
- I understand it is my responsibility to notify this office immediately of any changes in my health status and/or any of the above information.
- I understand and agree, (regardless of my insurance); I am ultimately responsible for the balance of all professional services/supplies rendered to me.
- I authorize the doctor and his staff to perform any necessary services needed during diagnosis and treatment to me (or my minor child).
- I authorize assignment of my insurance rights and benefits directly to the provider for services rendered.
- I authorize the provider to release any information required to process insurance claims and pursue final payment.
- In signing this form, I authorize this office to obtain a credit report, if necessary, to pursue final payment.

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Guardian: _____

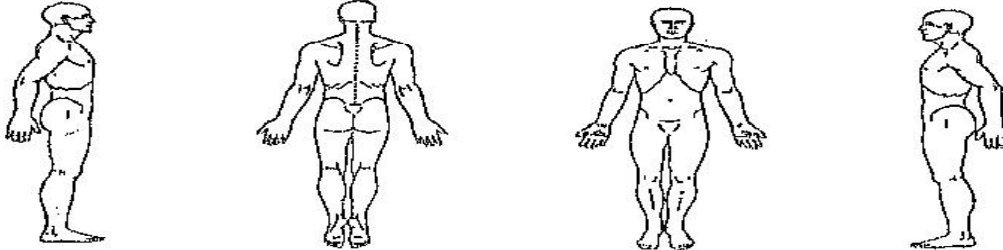
Symptoms Report Form

Mooney Chiropractic

Patient's Name: _____ Account #: _____

Describe the location(s) of your current symptom(s): _____

Mark the location of your current symptoms (with an "X") on the diagrams below:



Describe the frequency of your symptoms: Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (25% or less)

Describe the intensity of your current symptoms: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

Since your symptoms began, are your current symptoms: Improving Getting Worse Not Changing

Please check below the character of your current symptoms (you may mark one or more answers):

sharp dull achy burning tingling shooting weakness throbbing numbness gripping/constricting

Please list the most recent date that your symptoms began or reoccurred: ____/____/____

Did your current symptoms occur due to a recent automobile accident? Yes No (If yes, please provide proof of your auto insurance)

Did your current symptoms occur due to a reported work injury or from performing your work duties? Yes No
(If "yes", please provide our office with Worker's Compensation Insurance Information so we may report your injury as required by law)

Please describe what you think may have caused your symptoms: _____

How have your symptoms affected your ability to perform your daily activities at home and at work? _____

What have you tried to alleviate these symptoms? _____

What makes your problem better? laying standing sitting walking movement inactivity other: _____

What makes your problem worse? laying standing sitting walking movement inactivity other: _____

Have you ever had the same or similar symptoms? Yes No Please describe (including dates, treatment, & results): _____

What is your current stress level? none minimal moderate great Is this usual for you? yes no

Please mark your current physical activity at work: sitting driving light manual labor moderate manual labor heavy labor

Please mark your current physical daily activity: no regular exercise light exercise moderate exercise heavy exercise

In order to help you reach your treatment goals, please check the type of care you are seeking for these symptoms.

- First Aid Care (Relieve Pain/Symptoms)
- Corrective Care (Relieve Pain/Symptoms; and Correct Problem causing pain/symptoms)
- Optimal Care (Relieve Pain/Symptoms; Correct Problem; Maintain Good Health; Prevent Future Conditions)

The best health services are based on a friendly, mutual understanding between provider and patient. Please feel free to discuss your treatment, conditions, and/or concerns with the doctor or staff at any time. We look forward to helping you reach your treatment goals.

Patient Signature: _____ Date: _____

Health History Form

Mooney Chiropractic

Patient's Name: _____ Account #: _____

Please check any of the following that apply to you, in the appropriate column. Thank You.

- | Past | Present | |
|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches/Migraines |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus (Ear Noises) |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in Swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Upper Arm/Elbow/Hand |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness/Tingling in Arm/Elbow/Hand |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper/Mid Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid Heart Beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Low back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Leg/Hip/Knee/Foot |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness/Tingling in Leg/Knee/Foot |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling of Joints (List Locations): |

Stiffness of Joints (List Locations):

- | | | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular In-coordination |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight Gain |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Menopausal Symptoms |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Rash/ Dermatitis/ Eczema |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Aortic Aneurysm |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina |

- | Past | Present | |
|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (date): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer (describe): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema (chronic lung disorders) |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Corticosteroid Use |
| <input type="checkbox"/> | <input type="checkbox"/> | Medications (Please list present medications) |

- | | | |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy (# of Births): _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Permanent Disability Rating |

Please list any past Surgical Procedures: _____

Dominant Hand: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both Height: _____ Weight: _____
--

Family History: Please mark the following that apply:
 Cancer Diabetes High Blood Pressure
 Cardiovascular Problems/Stroke

Patient Consent Form

Mooney Chiropractic

Patient Name: _____ Account #: _____

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or the above mentioned patient, which I am legally responsible) which are recommended by Joey L. Mooney, D.C. and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for Mooney Chiropractic.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to; fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebrals strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts he knows, are in my best interest.

I will exercise my right to discuss with the doctor and/or his office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures in order to have all my questions answered to my satisfaction prior to treatment. I further understand that the results are not guaranteed.

I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) of which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Patient's Signature: _____ Date: _____

Signature of Patient's Representative: _____ Relations: _____

Patient Privacy Disclosure

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing below. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Consent. Mooney Chiropractic provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations (including but not limited to verifying insurance benefits and confirming appointments).
- Mooney Chiropractic has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- Mooney Chiropractic reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but Mooney Chiropractic does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Mooney Chiropractic may condition treatment upon the execution of this Consent.

Signature of Consent: _____ Date: _____

This consent signed by (printed name): _____ Relation: _____