



**Dynamic Chiropractic LLC**  
**720 E. Main St. Suite 1D**  
**Moorestown, NJ 08057**  
**856.222.1500**

Today's Date: \_\_\_\_\_

Name \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M  F

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Marital Status: Single  Married  Separated  Divorced  Widowed

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

**Other Health Care Provider you are seeing:**

Date	Name and Type (MD, DO, DC, etc)	Results
_____	_____	_____

Height: \_\_\_\_\_ Feet:Inch Weight: \_\_\_\_\_ lbs Handedness: Rt \_\_\_ Lt \_\_\_

**Why are you seeking chiropractic care:**

\_\_\_\_\_

**When and how did this start?** \_\_\_\_\_

Does this interfere with your: Sleep  Work  Daily Activities

On a scale from 1-10, 1 being no pain, rate your pain today? \_\_\_\_\_

What makes it better? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

**Describe your condition:**

Constant  Comes & Goes  Localized  Radiating

Numb/Tingling  Stabbing/Sharp  Burning  Ache

**Do you have difficulty:**

Sitting  Standing  Bending forward  Bending Backwards

Walking  Lifting  Reaching overhead  Other \_\_\_\_\_

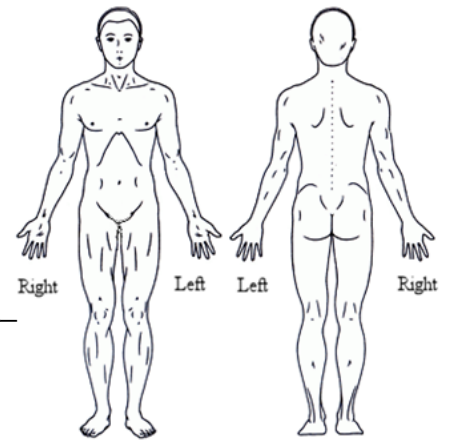
Is this related to work or auto accidents? Y  N

Are you in litigation for any accidents? (Auto, Worker's Comp, etc) Y  N

Is there anything else the Doctor or Staff should know?

\_\_\_\_\_  
 \_\_\_\_\_

**Mark where you are experiencing symptoms**





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**Family History**

Y N Diabetes  
Y N High Blood Pressure  
Y N Heart Disease  
Y N Musculoskeletal Disease  
Y N Cancer: \_\_\_\_\_  
Y N Stroke/aneurysm  
Y N Osteoporosis  
Y N Other: \_\_\_\_\_

**Current General History**

Y N Unexplained Wt Change, Inc or Dec.  
Y N Allergies: \_\_\_\_\_  
Y N Bleeding/Bruising  
Y N HIV  
Y N Cancer: \_\_\_\_\_  
Y N Insomnia  
Y N Other: \_\_\_\_\_

**Endocrine History**

Y N Thyroid Condition: Hyper/Hypo  
Y N Diabetes  
Y N Other: \_\_\_\_\_

**Eye/Ear/Nose/Throat**

Y N Eye or Ear Pain  
Y N Other Visual Conditions  
Y N Change in vision/hearing/taste  
Y N Ringing in Ears  
Y N Dizziness  
Y N Difficulty Chewing/Swallowing

**Gastrointestinal System**

Y N Anorexia/Bulimia  
Y N Constipation/Diarrhea  
Y N Nausea/Vomiting  
Y N Abdominal Pain/Swelling  
Y N Gallbladder Disease  
Y N Liver/Pancreatic Disease: \_\_\_\_\_

**Urinary System**

Y N Urinary Urgency/Pain  
Y N Difficulty holding/expelling  
Y N Kidney Disease/Stone/Pain  
Y N Prostate Issues  
Y N Pelvic Pain

**Cardiovascular System**

Y N Heart Medications: \_\_\_\_\_  
Y N Past heart or vascular disease  
Y N Chest discomfort/pain

Y N Palpitations  
Y N Edema  
Y N High blood pressure  
Y N Blood clot/aneurysm/DVT  
Y N Sudden calf pain with walking  
Y N Other: \_\_\_\_\_

**Skin/Hair/Nails**

Y N Skin Cancer  
Y N Rashes/itching/lesions  
Y N Psoriasis

**Neurological System**

Y N Headaches  
Y N Seizures/epilepsy  
Y N Vertigo  
Y N Loss of sensation  
Y N Head Trauma  
Y N Multiple Sclerosis  
Y N Vertebral Disc Condition  
Y N Anxiety/Bipolar/Depression

**Musculoskeletal System**

Y N Osteoporosis/Fibromyalgia  
Y N Arthritis: \_\_\_\_\_  
Y N Scoliosis  
Y N Joint pain/stiffness/swelling  
Y N Muscle cramp/soreness/pain  
Y N Neck pain  
Y N Upper/Mid back pain  
Y N Low back pain  
Y N Shoulder/arm/hand pain  
Y N Leg/knee/foot pain  
Y N Fractures/dislocation/sprains  
Y N TMJ issues

**Pulmonary System**

Y N Asthma/Shortness of Breath  
Y N Apnea  
Y N Pneumonia  
Y N Cigarette Smoking  
Y N Respiratory Infections  
Y N Other: \_\_\_\_\_

**Implants/Orthotics**

Y N Cardiac/Pacemakers  
Y N Joint replacement/Pins/plates/screws

**Diet/Exercise**

Y N Consume caffeine  
Y N Consume alcohol



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List any surgeries/hospitalizations:

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List all current medications/supplements:

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## **Consent to Chiropractic Care**

- I understand that my health records are the property of Dynamic Chiropractic LLC and will be protected under HIPAA. At any time, I have the right to request a copy of my health records which will have a fair material value fee to copy.
- I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled "Notice of Privacy Practices". I understand that I may review this notice at any time prior to signing this form.
- I authorize Dynamic Chiropractic to release information to any health care provider I am seeing and / or insurance company.
- I understand that any all payments are inherently my responsibility. I agree to my insurance company to be billed for payment and that I accept responsibility for what my insurance company may not cover. I agree to pay any balance associated with my care.
- I give my permission for my Doctor and staff at Dynamic Chiropractic to communicate by telephone or email regarding matters of chiropractic care, appointment reminders or scheduling.
- A parent must accompany his/her minor child on the first visit to Dynamic Chiropractic and sign a consent to treat minor for any additional visits where the Parent/Guardian will not be present.
- I authorize Dynamic Chiropractic to administer care as needed, as indicated from examination findings. Chiropractic adjustments are exceedingly safe when applied properly. However, I understand there are some risks to care including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to anticipate and explain every risk and complication, but I will rely on the doctor's best judgement to protect my best interests. No Guarantees of cure have been implied or given.
- The Doctor of Chiropractic will discuss any further risks inherent for my case. I understand that I am an active participant in my chiropractic care and that I am encouraged to bring up questions or express any concerns.
- I have reviewed and certify that all the information that I have reported above is true to the best of my knowledge and that I have read and understand the Consent to Chiropractic Care above.

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Patient/Guardian's Signature

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Date

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Doctor Signature

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Date