Michele Moul, D.C.

1331 El Camino Drive, Pekin, Illinois 61554 (309) 347-0404

WELCOME TO OUR OFFICE!!

Date_____

Confidential Patient Information:

First Name_____ MI_____ Last Name_____

Date of birth_____ Social Security Number_____ Medicare Y N

Home address_____ City_____

State_____ Zip code_____ Email Address_____

Home phone_____ Cell phone_____

Employer_____ Work phone_____

Name of Spouse_____ Spouse's Employer_____

In case of emergency, whom should we contact? _____

Relationship_____ Phone_____

Purpose of this appointment_____

Other doctor seen for this condition_____

Have you been treated by a doctor for any health condition in the last year? _____
If so, whom? _____

Who may we thank for referring you to our office? _____

Financial Policy

Payment is expected at the time services are rendered. We do not accept insurance assignment, but you will be given a form to submit to your insurance carrier so that the reimbursement will come directly to you according to the terms of your policy. There will be a charge for cancelled appointments unless a 24-hour notice is given.

I understand this financial policy.

Signature_____ Date_____

Consent for Treatment

Patient Name_____

Please check all boxes that apply:

☐ I hereby authorize Michele Moul, D.C. to examine and treat my condition. I acknowledge that no guarantee for treatment results have been made.

☐ I hereby authorize Michele Moul, D.C. and her designated assistants to administer treatment to my child, _____, as she deems necessary.
(patient name)

☐ This is to certify that to the best of my knowledge I am not pregnant and Dr. Moul and her associates have my permission to perform diagnostic X-ray examination if necessary. I understand that X-rays can be hazardous to an unborn child.

☐ I hereby authorize Michele Moul, D.C. to release information to any physician or health care facility involved in the patient's care.

☐ I understand the items above indicated above pertaining to me or my child.

_____ _____
Patient signature, or parent if patient is a minor Date

_____ _____
Witness Date

MICHELE MOUL, D.C.
1331 EL CAMINO DRIVE, PEKIN, IL 61554
PHONE: (309) 347-0404 FAX: (309)347-0407

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Date: _____

Other than the above mentioned, I also authorize Michele Moul, DC to disclose requested protected health information about me to the following person(s):

_____
Name of person(s) whom we can disclose your PHI (spouse, child, caregiver, significant other, sibling, etc.)

_____
Signature of Patient or Legal Guardian

Confidential Patient History

Name_____ Birth date_____ Age _____ Date_____

1. Please list the primary complaint(s) for which you are seeking help and the *exact* location of your pain, if you are here for ***wellness care***, check here ☐ and skip to question #16.

_____

_____

_____

_____

2. When did your pain first begin?_____

3. Was the onset sudden or gradual?_____

4. What caused this condition and was there an injury or unusual activity involved?_____

_____

5. What type of pain is it? (please circle) sharp / dull / burning / tingling / aching / stiff / sore / boring/ excruciating / other_____

6. Is the pain? constant / frequent / come and goes / occasional / mild / moderate / severe

7. Does the pain radiate, does it travel? ☐ yes ☐ no If yes, where? (please circle L/R and location)

Into the left or right: shoulder / upper arm / elbow / forearm / wrist / hand / fingers
buttocks / front of leg / side of leg / back of leg / knee / calf / ankle / foot / toes

8. Has the type of pain or intensity of pain changed since it began? ☐ yes ☐ no If yes, how?___

_____

9. What makes the pain feel better?_____

10. What makes the pain feel worse?_____

11. When do you typically feel the pain? (check all that apply) ☐ morning ☐ afternoon ☐ evening ☐ after working ☐ after activity ☐ always ☐ other_____

12. Have you ever had this problem before? ☐ yes ☐ no If yes, when and what treatment did you receive? _____

13. What activities is your pain currently affecting? ☐ sleep ☐ work ☐ exercise ☐ dressing ☐ grooming ☐ daily schedule ☐ recreational activities ☐ other_____

14. Have you received any other treatment for this complaint? ☐ yes ☐ no If yes, please list the date, Dr's name and treatment you received_____

_____

15. Are you taking any prescribed or over the counter medications for this problem?_____

_____

(Continued on next page)

Patient History continued:

Patient name_____ Date _____

16. Please list all medications and vitamins you are taking presently_____

_____

17. Have you seen a chiropractor before? ☐ yes ☐ no If yes, when was your last adjustment?_____

_____Who was your doctor_____

18. Have you ever been in an accident, including auto, falls, work related or other?☐ yes ☐ no

If yes, when, and explain_____

_____

19. Are ther any family members with spinal related problems? ☐ yes ☐ no If yes, please list_____

_____

Please check if your parents or siblings have ever had:

☐ Diabetes _____
☐ Heart Disease _____
☐ Hypertension_____
☐ Stroke_____
☐ Cancer _____
☐ Arthritis_____

20. Give the dates you have had any of the following: Physical exam_____ Blood test_____

Urinalysis _____ Pap smear_____ X-ray exam_____ MRI/CT exam_____

21. Please check all habits that apply and frequency or amounts:

☐ Cigarettes _____ packs per day, for _____ years.
☐ Alcohol, amount per week _____
☐ Sleep _____ hours per night
☐ exercise ____ times per week
☐ Water_____ glasses per day ☐ soda _____ cans per day
☐ Coffee ____ cups per day ☐ tea _____ cups per day

22. Have you been treated for alcohol or substance abuse? ☐ yes ☐ no

23. Women only:

Are you pregnant? ☐ yes ☐ no

Date of first day of last menstral period_____

Patient Signature_____ Date_____

Doctor's comments_____

_____

_____

_____

Name_____ **DOB** _____ **Age** ____ **Date**_____

Please **circle** those symptoms you have **now. Underline** those you have had **previously.**

1. Headaches
2. Fever
3. Chills
4. Night sweats
5. Fainting
6. Dizziness
7. Convulsions
8. Loss of sleep
9. Fatigue
10. Nervousness
11. Depression
12. Numbness
13. Pain
14. Sudden weight loss
15. Weight gain
16. Allergies
17. Wheezing
18. Nausea
19. Vomiting
20. Cancer
21. Diabetes
22. Arthritis
23. Failing vision
24. Near sightedness
25. Far sightedness
26. Blurred vision
27. Hearing loss
28. Earaches
29. Ear noises
30. Ear discharge
31. Imbalance/vertigo
32. Sinus infection
33. Nose bleeds
34. Difficulty breathing
35. Runny nose
36. Sore throat
37. Hoarseness
38. Dental decay
39. Gum disease
40. Frequent colds
41. Enlarged thyroid
42. Excessive thirst
43. Enlarged glands
44. Hay fever
45. Jaw pain
46. Skin eruptions
47. Itching
48. Rashes, sores, lumps
49. Moles
50. Chronic cough
51. Coughing up phlegm
52. Coughing up blood
53. Chest pain
54. Difficulty breathing
55. Shortness of breath
56. Asthma
57. Emphysema
58. Lung problems
59. Rapid heartbeat
60. Slow heartbeat
61. High blood pressure
62. Low blood pressure
63. Previous heart trouble
64. Swelling of ankles
65. Poor circulation
66. Pacemaker
67. Neck pain
68. Stiff neck
69. Mid back pain
70. Low back pain
71. Hip pain
72. Shoulder pain R/L
73. Knee pain R/L
74. Leg pain R/L
75. Swollen joints
76. Stiff joints
77. Painful joints
78. Wrist pain
79. Elbow pain
80. Ankle pain
81. Numbness in fingers
82. Tingling in arms
83. Numbness in toes
84. Tingling in legs
85. Weakness in arms
86. Weakness in legs
87. Pain when bending
88. Pain when standing
89. Pain when sitting
90. Pain when walking
91. Muscle spasms
92. Frequent urination
93. Painful urination
94. Hesitancy w/urination
95. Urgency w/urination
96. Lack of Urine control
97. Kidney stones
98. Prostate trouble
99. Hernia
100. Poor appetite
101. Poor digestion
102. Excessive hunger
103. Gas problems
104. Vomiting blood
105. Stomach pain
106. Difficulty swallowing
107. Constipation
108. Diarrhea
109. Bloody stool
110. Black stool
111. Colon trouble
112. Hemorrhoids
113. Liver trouble
114. Gall bladder trouble
115. Jaundice
116. Colitis

117. Anything else we should know about your health?

_____
_____
_____
_____
_____
_____
_____
_____

For women only ~

Painful menstrual flow
Excessive flow
Irregular flow
Cramps or backache
Previous miscarriage
Vaginal discharge
Pain in breast R/L
Lump in breast R/L
Skin changes in breast
Breast discharge
Menopausal symptoms
Hot flashes
Pregnant Y/N
Back pain
Hip pain
Leg pain

Patient's signature _____ Date: _____

Doctor's comments _____

_____

_____

_____

_____