Welcome To

Caring For Patients From All Over The World!

New Patient Entrance Form

Welcome to a completely new approach in Chiropractic Care!

Dr. Moyal is considered as ***One of the Best Spinal & Extremity Adjuster and Top Sports Chiropractor*** in the Country. His approach has attracted patients from 78 Countries to date, as well as, top professional, Olympic athletes and celebrities for the last 24+ years.

He is an author, lecturer, seminar instructor and father who loves to serve and help as many people as he can come in contact with and that want to let him help them resolve their chronic or unique problems.

His specialized approach is a favorite with athletes as they begin to perform and recover better, faster and with less injuries under his skillful hands and approach to their customized personal care. They now realize and achieve greater performances and get closer to reaching their goals as elite athletes and/or even weekend warriors.

So, get ready to have an amazing experience with a true ***Master of the Art of Chiropractic Care and Sports Injuries Resolution.*** We guarantee you have NEVER had the type of care or exam you are about to receive from the Doctor who developed this unique and precise approach to finding and correcting your chronic problem(s)!

PATIENT INFORMATION

Date_____

Name_____

Address_____Apt#____

City_____ State_____ Zip _____

Cell Phone _____ SS#_____

Birth Date___/____/____ Age _____ Sex _____

O Married O Single O Divorced O Widowed

Whom may we thank for referring you? _____

Is there someone you would like to refer? Yes No

What name do you prefer to be called? _____

Your Email address _____@_____

We offer an amazing format of Health Tips & Latest Health Trends. Would you like to be included? **Yes No**

EMPLOYMENT INFO

Occupation_____

Employer _____

Address_____

_____

Phone #_____

EMERGENCY INFO

Contact Name _____

Relationship_____

Phone # _____

MOYAL CHIROPRACTIC
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Email: **drmkiro4u2@aol.com**

As you know, you are fully responsible for your bill. We cannot guarantee that your insurance will cover you completely. Insurance agreements are between the policy owner and the insurance company, not with our office. In such case that your insurance doesn't pay as agreed, any balance owed will be your responsibility to clear up. As a courtesy we work with many companies. I understand that I am fully responsible for any bills. Today and in the future my billing will be handled between myself and my:

O Spouse/Partner O Health Insurance O Auto Insurance

Previous chiropractic care: O None O Doctor's name & approximate date of last visit _____

CURRENT HEALTH CONDITION(s)

What is Your Present Unwanted Health Condition: _____

When did the symptoms first appear? _____

Has this condition occurred before? O Yes O No

How often do you experience the symptoms?

O Constant 100% O Frequent 75%

O Intermittent 50% O Occasional 25% O Rare 10%

What makes the symptoms worse? _____

What relieves the symptoms? _____

How would you describe the pain?

O Sharp O Dull O Aching O Burning O Numb

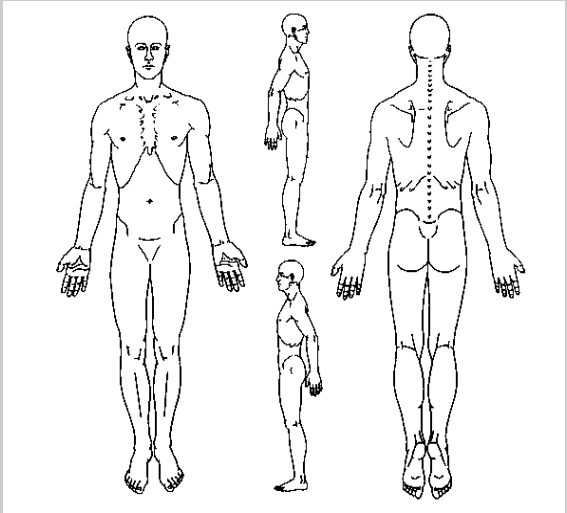
O Throbbing O Radiating O Deep O Other_____

Rate the pain on a scale of 1-10 (10 being unbearable pain):

Right Now 1----2----3----4----5----6----7----8----9----10

At Its Worst 1----2----3----4----5----6----7----8----9----10

[Mark your areas of concern on figure]



Other Doctors Seen For This Condition: O Yes O No Who? _____

Type of treatment? _____ **Results?** _____

Is this condition: O Auto Accident O Home Injury O Workout Injury O Fall O Other:_____

Do you wear a shoe lift? Orthotics? O Yes O No

Do you suffer from any condition(s) other than that which you are now consulting us for? _____

_____

How is your sleep? ○No Problem ○Good ○Not so good ○Wake up during the night ○Can't sleep
How is your Energy Level? ○No Problem ○Good ○Not so good ○What energy?

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE OR HAD

○AIDS/HIV	○Arthritis	○Diabetes	○Gout	○Osteoporosis
○Anemia	○Cancer	○Epilepsy	○Multiple Sclerosis	○Rheumatic Fever

CHECK ANY YOU HAVE OR HAD IN THE PAST 6 MONTHS

Musculoskeletal Code
○General Stiffness
○General Weakness
○Swollen Joints
○Spinal Curvature
○Neck Pain
○Arm Pain
○Pain Between Shoulders
○Low Back Pain
○Foot Trouble
○Walking Problems
○Jaw Problems

Nervous System Code
○Nervous
○Numbness
○Dizziness
○Forgetfulness
○Depression
○Cold/Tingling Extremities
○Stress
○Twitching

General Code
○Fatigue
○Allergies
○Headache
○Loss of Sleep
○Weight Loss ?____lbs
○Fever
○Thyroid Problems

Gastrointestinal Code
○Poor/Excessive Appetite
○Excessive Thirst
○Vomiting
○Nausea
○Diarrhea
○Constipation
○Liver Problems
○Gall Bladder Problems
○Abdominal Cramps
○Gas/Bloating/Belching
○Heartburn
○Black/Bloody Stools
○Colitis

C-V-R Code
○Chest Pain
○Short Breath
○Asthma
○Blood Pressure Problems
○Irregular Heartbeat
○Heart Problems
○Lung Problems
○Varicose Veins
○Ankle Swelling
○Stroke

EENT Code
○Vision Problems
○Dental Problems
○Sore Throat
○Ear Aches
○Hearing Difficulty
○Stuffed Nose
○Frequent Colds
○Nose Bleeds
○Sinus Trouble
○Hoarseness

Genitourinary Code
○Bladder Trouble
○Painful/Excessive Urine
○Discolored Urine

For Women Only
○Cramps
○Irregular Cycle
○Painful Periods
○Pregnant (now)

Family History
The following members have a same or similar problem as I do:
○Father
○Mother
○Brother
○Sister
○Child
○Other_____

HEALTH HABITS

Exercise/Sports/Hobbies:

1)Type _____ Frequency _____ **2)Type _____ Frequency _____**
3)Type _____ Frequency _____ **4)Type _____ Frequency _____**

Sleep: **Hours/night ___ Sleep quality _____** Do you sleep on your: ○Back ○Side ○Stomach

Smoking/Drinking/Diet: **(how much and how often)**

Tea/Coffee _____ Liquor/Beer _____ Cigarettes/Tobacco _____

OCCUPATIONAL INFORMATION

Job involves: ○ Sitting ○ Standing How long? _____ Computer # of hours ○ <4 ○>4-8

○ Bending ○ Stooping ○ Twisting ○ Turning ○ Lifting - How much weight? _____

Physical activity at work: ○Sedentary ○Light manual labor ○Heavy labor

Telephone use at work: ○None ○Moderate ○Heavy ○Traditional receiver ○Headset

Do any work activities aggravate your complaints? _____

_____

Is your computer directly in front of you when you are using it? Yes No At an angle Left Right

PAST HEALTH HISTORY

Please list ALL surgeries, hospitalizations, fractures/dislocations you have had:

Type _____ **When** _____
Type _____ **When** _____
Type _____ **When** _____

Please list ALL previous accidents and falls:

What _____ **When** _____
What _____ **When** _____
What _____ **When** _____

Please list ALL medications and/or vitamins you take:

Name_____ **For What**_____ **Name**_____ **For What**_____
Name_____ **For What**_____ **Name**_____ **For What**_____
Name_____ **For What**_____ **Name**_____ **For What**_____

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Most patients that come to our office have one of three objectives in mind concerning their health. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want to be able to function better and perform at a higher level biomechanically, while also improving their immune system through getting periodic adjustments after your problem has been resolved ***(Performance Care)***. The doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

○ *Relief Care*

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Good Choice

○ *Corrective Care*

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Better Choice

○ *Performance Care*

Performance Care was originally reserved for top athletes and Olympians, but as they retired and continued to get adjusted we noticed that they continued to improve, feel better, have less aches & pains, health problems or chronic degenerative problems than our regular patient base.

Best Choice

○ **Check here if you want the doctor to select the type of care appropriate for your condition.**

METHOD OF PAYMENT ○ **Cash** ○ **Check** ○ **Credit/Debit**

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my health status. ***I also understand that I am solely responsible for my charges whether or not my insurance covers me.***

Signature _____ **Date** _____

DO NOT WRITE BELOW THIS LINE

DIAGNOSES: 1. _____ **2.** _____ **3.** _____ **4.** _____ **5.** _____

Patient Accepted: ○**Yes** ○**No** ○**Referred Out** **Doctor's Signature**_____