Molland Spinal Care, LLC
124 Hwy 35 South
Red Bank, NJ 07701 Phone: 908-601-5600

Welcome to Molland Spinal Care, LLC.

Enclosed please find a patient questionnaire. Please fill out the parts that relate to your specific condition and symptoms to the best of your ability. The more information you can provide to Dr. Liz Molland and Dr. Zach Molland, the better they will understand the nature of your problem(s).

A series of x-rays will be taken at your appointment. Please refrain from wearing clothes with metal, buttons, zippers, clips, jewelry, snaps, etc. Please remove all earrings and piercings on the entire body. We suggest wearing sweatpants or shorts and a comfortable t-shirt for both men and women. A sports bra is recommended for women, as there are typically no metal hooks. By following the above guidelines, it may not be necessary for the patient to have to change into a gown.

Molland Spinal Care, LLC

Please be sure to bring your driver's license and insurance card (Medicare patients only) with you to your appointment.

Molland Spinal Care, LLC
Patient Registration

Patient Information

Legal Name:_____ _____ _____
First Middle Last

(Nickname:)_____

Gender: (M F) Date of Birth:_____ Age:_____
Please Circle

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____ Cell Provider:_____

Marital Status: Single Married Divorced Driver License No._____ State:_____

Please Circle Below
Race:

American Indian, Alaskan Native
Asian, Middle Eastern, Indian
Black or African American
Hispanic or Latino
Native Hawaiian, Pacific Islander
White

Please Circle Below
Ethnicity:

Hispanic or Latino
Or
Not Hispanic or Latino

Preferred Language
English
Spanish
Other

Please Circle Below
Smoking Status:

1. Smoke every day
2. Current some day smoker
3. Former Smoker
4. Never Smoker

Please Circle Below
Employment Status: Employed Unemployed Retired Disabled

Employment Information
Employer Name:_____ Occupation:_____

Employer Address:_____ Phone No :_____

Spouse's Information
Name:_____ Phone:_____

Emergency Contact
Name:_____Relationship:_____Phone: _____

How did you hear about us? □Website □NUCCA.org □Met the Doctor □Other:_____

Patient/Guardian Signature:_____ **Date**:_____

HISTORY OF MEDICATIONS:

Medications, Vitamins, Minerals, Supplements, that are currently being taken (including aspirin, Tylenol, birth control pills, etc.)

Name	Size/Amount	How Often Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you used antibiotics in the last 10 years: Yes No

If yes, explain how often and for what:_____

Additional Questions:

Do you wear: ☐ Heal Lifts ☐ Sole lifts ☐ Inner Soles ☐ Arch Supports ☐ None

_____

Have you had other medical imaging such as X-rays/CTs/MRIs that have led to a diagnosis?
☐Yes ☐No

_____

MEDICAL HISTORY:

IN THE SPACES PROVIDED, PLEASE INDICATE IF YOU EXPERIENCE ANY TRAUMA OR RECEIVED CARE FOR ANY SICKNESS OR INJURY. (IF NOT ENOUGH SPACE, CONTINUE ON BACK.)

Medical problems or injuries from:

Birth- age 5 (Y or N):_____

Age 5-18 (Y or N):_____

Age 18-25 (Y or N):_____

Age 25-35 (Y or N):_____

Age 35-45 (Y or N):_____

Age 45-55 (Y or N):_____

Age 55-65 (Y or N):_____

Age 65-on (Y or N):_____

IF YOU NEED MORE ROOM TO EXPLAIN ADDITIONAL PROBLEMS, PLEASE CONTINUE ON TO THE BACK OF THIS PAGE.

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1=Mild 10=Unbearable	When did this episode start?	If you had the condition before when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1.					
2.					
3.					
4.					
5.					

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES/NO

CHIROPRACTOR?_____ MEDICAL DOCTOR?_____ OTHER_____

WHO AND WHEN?_____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

DIZZINESS	***THROAT ISSUES***	***KIDNEY PROBLEMS***	***LIVER DISEASE***	***NERVOUSNESS***
HEADACHES	***THYROID PROBLEMS***	***MID BACK PAIN***	***SHOULDER PAIN***	***EPILEPSY***
VERTIGO	***ASTHMA***	***IRRITABLE BOWEL***	***CHRONIC FATIGUE***	***DISC PROBLEM***
EAR INFECTIONS	***ULCERS***	***SCIATICA***	***LUPUS***	***INFERTILITY***
NAUSEA	***NUMBNESS IN ARMS***	***NUMBNESS IN LEGS***	***FIBROMYALGIA***	***GASTRIC REFLUX***
TMJ	***NUMBNESS IN HANDS***	***NUMBNESS IN FEET***	***CHEST PAIN***	
NECK PAIN	***MENSTRUAL DISORDER***	***LOW BACK PAIN***	***ARM PAIN***	***OTHER_____***
MIGRAINES	***HEART DISORDERS***	***HIP PAIN***	***ADD/ADHD***	_____
ANXIETY	***STOMACH DISORDERS***	***LEG PAINS***	_____	_____
CHRONIC SINUS	***BLADDER PROBLEMS***	***KNEE PAIN***	_____	_____

ANY OTHER ISSUES OF YOUR OWN YOU WISH TO EXPLAIN:

_____

_____

_____

FAMILY HISTORY:

PLEASE CHECK BOXES BELOW TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

ANY OTHER FAMILY ISSUES YOU WISH TO EXPLAIN:

_____

_____

Patient's Signature:_____