MORRIS FAMILY CHIROPRACTIC

Name _____ Address _____

City _____ State _____ Zip _____ Home ph:_____ Cell ph:_____

SSN _____Date of birth _____ Age _____ Height _____ Weight _____

E-mail: _____

Male • Female • Single • Married • Divorced • # of children _____ Name of spouse (or parent)

_____

Employer _____ Address _____

City _____ State _____ Zip _____ Wk phn _____ Occupation:_____

How did you hear about our office:_____

Have you ever had Chiropractic care before? _____ If yes, when? _____

If you are experiencing any health problems, please list your chief complaints in order of severity (pain, symptoms, etc.)

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

Has the chief complaint been getting better, worse, or staying the same?_____

What makes it worse? _____

What makes it better? _____

Have you been involved in an auto accident in the last 12 months? __ Yes __

Have you ever had any surgeries or hospitalizations? _____ If yes, please list:_____

Please list any injuries or illnesses that you have had that are not listed above:_____

Please indicate medications (over the counter) / prescriptions you are currently taking: • Aspirin/Tylenol •Pain killers •Muscle Relaxers •Insulin •Tranquilizers •Birth Control Pills •Others: _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke **Y N** Heart Surg. / Pacemaker **Y N** Alcohol / Drug Abuse

Y N Venereal Disease **Y N** Hepatitis **Y N** HIV/ Aids

Y N Cancer **Y N** Frequent Neck Pain **Y N** High/ Low Blood Pressure

Y N Psychiatric Problems **Y N** Severe/ Frequent Headaches **Y N** Ulcers / Colitis

Y N Fainting/ Seizures/ Epilepsy **Y N** Sinus Problems **Y N** Asthma

Y N Diabetes / Tuberculosis **Y N** Difficulty Breathing **Y N** Chemotherapy

Y N Lower Back Problems **Y N** Artificial Bones / Joints **Y N** Arthritis

Do you smoke? **Y N** How much ? _____ How Long? _____ What is the age of your mattress ? _____

For Women: Are you taking Birth Control? **Y N** Are you pregnant? **Y N** Expected date of delivery?__/___/_

Person Ultimately Responsible for Account:
Name:_____ Relation:_____ Date of Birth: _____/_____/_____
Billing Address:_____ City:_____ State:_____ Zip:_____
Social Security Number (for insurance purposes) :_____-_____-_____
I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. _____(initials)

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR CURRENT TYPICAL LEVEL OF ACTIVITIES AS THEY ARE NOW. 0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

0 1 2 3 4 5 6 7 8 9 10

Completely able to function **Totally unable to function**

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc. _____

2. RECREATION: hobbies, sports, and other similar leisure time activities.
_____

3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions.
_____

4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker.
_____

5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.)
_____

6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing.
_____

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking etc.

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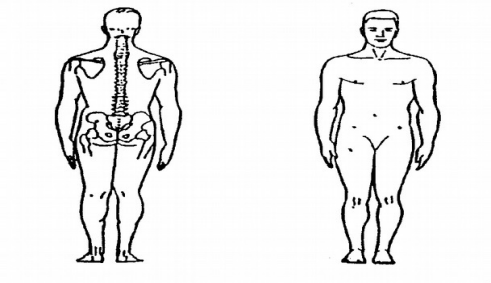
COMPLETE THESE DIAGRAMS



1. We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient:
2. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
3. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
4. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient's Signature_____ **Date:**_____