

Welcome to Optimum Natural Health Care At Morris Chiropractic Clinic 210 Atlantic Avenue Morris, MN 56267

Patient Information

Thank you for choosing our practice for your natural health care needs. Please complete this form in black ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Date of Birth: _____ Age: _____ Sex: ___Female ___Male

Marital Status: S M D W S Social Security # _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____

Email Address: _____ (for office announcements, weekly health update, monthly newsletter, rehab program information, other health information)

*Do we have your permission to contact you at any of your above listed phone numbers? Yes

If No, circle which phone number: Home Cell Work

Patient Employer/School _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Spouse's or Parent's Name _____ Parent's Employer Work Phone # _____

Spouse Birthdate: _____

How were you referred to us? Patient (If patient, patient name: _____) Phone Book: Dex Federated Telephone Yellow Book Internet Friend Doctor Other: _____

Person to contact in case of emergency: _____ Relationship: _____

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

Name of Employer _____ Work Phone #: _____

Insurance Information

Insurance Company Name: _____ Name of Subscriber _____ Relationship to patient _____

Insurance ID#: _____ Group #: _____ Subscriber Birthdate _____

DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE FILL IN THE INSURANCE CO. NAME, ID#, GROUP# & Insured's Name _____

Responsible Party

Name of person responsible for this account _____ Birthdate: _____

Relationship to patient _____ Phone #: () _____

Address _____ City _____ State _____ Zip _____

Symptoms

What symptom(s) are you having? _____

When did your symptom(s) begin? _____

What do you think caused your symptom(s)? _____

Where specifically are your symptom(s) located? _____

Which activities are difficult for you to perform? **Sitting Standing Walking Bending Lying Down**

Other: _____

What type of Pain do you have: **Sharp Stabbing Dull Throbbing Constant Intermittent Aching Shooting Burning Tingling Cramping Stiffness Pins and Needles Radiating Other:** _____

Rate the severity of your pain (1-mild pain or discomfort, to 10-severe pain): _____

What activities make your symptom(s) worse? _____

What activities make your symptom(s) better? _____

Are your symptom(s) worse during certain times of the day? **Yes No** If Yes, when? _____

Are your symptom(s) getting progressively worse? **Yes No Other:** _____

Do you ever experience ripping or tearing sensations in your back? **Yes No** If Yes, where: _____

Do you have lower back pain which radiates into your abdomen? **Yes No**

Do have any problems with your bowel or bladder function? **Yes No**

Does it cause you pain to cough, grunt or sneeze? **Yes No**

What is your dominant hand? **Right Left**

Do you have any additional symptoms? **Yes No** If Yes, list: _____

What treatment have you already received for your condition? **Medication Physical Therapy Surgery None**

Other: _____

List all medications you currently take: _____

Name and address of other doctor(s) who have treated you for your

symptom(s): _____

Date of last: Physical Exam _____ Spinal Exam _____ Eye Exam _____ Dental Exam _____ Hearing Exam _____ Spinal X-Ray _____

Chest X-Ray _____ MRI _____ CT-Scan _____ Bone Scan _____

Accident Information

Are your symptom(s) due to an Accident? **Yes No** If Yes, when?: _____

Type of accident: **Auto Work Home Other:** _____

To whom have you made a report of your Accident? **Auto Insurance Agent Employer Workers Compensation**

Other: _____ **If Employer, who:** _____

Health History

Circle if you have had any of the conditions listed below:

AIDS/HIV Arthritis Asthma Back Pain Cancer Depression Diabetes Dizziness Emphysema Epilepsy Glaucoma Headaches Heart Disease Hepatitis Hernia Herniated Disc Herpes Kidney Disease Liver Disease Loss of Balance Loss of Memory Migraine Headaches Multiple Sclerosis Neck Pain Osteoporosis Pacemaker Parkinson's Disease Polio Prostate Problems Prosthesis Psychiatric Care Rheumatic Fever Ringing in Ears Scarlet Fever Sleeping Problems Stroke Thyroid Problems Tuberculosis Venereal Disease Pins & Needles in Arms/Legs Numbness in Fingers/Toes Hands/Feet Cold Neck/Upper Back/Mid Back/Low Back Stiff Other _____

Does anyone in your immediate family have a history of the symptoms you have today? **Yes No** If yes, list who: _____

(Women) Are you pregnant? **Yes No** If Yes, Due Date: _____

List any types of surgeries which you have had and the dates which they occurred: _____

Daily Habits

Do you exercise? **Yes No If Yes: Light Moderate Heavy Daily**

What do your daily work habits include? **Sitting Standing Light labor Heavy Labor Other:** _____

Do you take nutritional supplements? **Yes No** If Yes, list: _____

Do you take medication? **Yes No** If Yes, list: _____

Are you allergic to any medication? **Yes No** If yes, list: _____

Do you smoke? **Yes No** If yes, how much per day? _____

Do you drink liquor? **Yes No** If Yes, how much per week? _____

Do you drink coffee or caffeinated beverages? **Yes No** If Yes, how much per day? _____

Do you have stress? **Yes No** If Yes, circle choice(s): **Mild Mild to Moderate Moderate Moderate to Severe Severe**

Informed Consent, Certification and Release of Information

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will gladly refer you to another provider who we feel can further assist you.

It is understood and agreed the amount paid the clinic for X-Rays's is for examination only and the X-Ray negatives will remain the property of this office, being on file where they may be seen upon request. Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkable safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Specific risk possibilities associated with chiropractic care: Soreness, Soft Tissue Injury, Rib Injury, Physical Therapy Burns, Stroke.

While these are rare, they should be reported to your doctor promptly. Treatment is performed carefully to minimize such risks. If you have any questions concerning this form or the above statements, please ask your doctor.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Morris Chiropractic Clinic responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Having carefully read the above, I hereby authorize the physicians and staff at Morris Chiropractic Clinic to treat my condition as deemed appropriate. I also certify that no guarantee or assurance has been made to the results that may be obtained.

Signature of Patient, Parent, Legal Guardian or Personal Representative _____ Date _____

Printed Name of Patient, Parent, Legal Guardian or Personal Representative _____ Date _____