CONFIDENTIAL PERSONAL HISTORY

PATIENT INFORMATION

Date_____

Name_____

Street Address/Apt. # _____

Town/State/ZipCode_____

Phone: (H)_____(B)_____(C)_____

Email_____

Age_____Birth date_____SS#_____

Sex: ☐ M ☐ F Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Occupation_____Employer_____

Referred By: ☐ Medical Doctor ☐ Insurance Co. ☐ Internet ☐ Other_____

Primary Care Physician_____

In case of emergency, contact (Name & Phone) _____

PATIENT CONDITION

Reason for visit_____

Date of onset_____Causes (if known)_____

Are your symptoms getting worse? YES / NO

Frequency of symptoms: Constant / Daily / Intermittent

What improves your symptoms?_____

What worsens your symptoms?_____

Doctors seen for this condition_____Date(s)_____

Their diagnosis_____Their treatment_____

Results of treatment_____

Tests for this condition X-ray MRI EMG Other_____

(Consultation Notes)

Name_____Date_____

HEALTH HISTORY

Previous chiropractic care: YES / NO
For what conditions?_____Date last treated_____

(Please record all history of trauma)

	Description / Injuries	Date(s)
Car Accidents		
Sports injuries		
Other Traumas		
Hospitalizations		
Surgeries		

Medications / Nutritional Supplements	Taking For

Are you pregnant? YES / NO Due date_____

PERSONAL HABITS:

- ☐ Coffee/Caffeine Cups/Day_____
- ☐ Alcohol Drinks/Week_____
- ☐ Smoking Packs/Day_____ # of years_____
- ☐ Exercise Days/Week_____ Type_____
- ☐ Sleep Hrs/Night_____ Quality: Good / Poor

Name_____ Date_____

Please check any condition or symptom you now have or have had in the past.

Past	Present	GENERAL
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Sweats
☐	☐	Cancer
☐	☐	Diabetes
☐	☐	Significant infections
☐	☐	Alcoholism/Substance abuse

		ALLERGIES
☐	☐	Environment_____
☐	☐	Foods_____
☐	☐	Drugs_____

		NEUROLOGIC
☐	☐	Headache
☐	☐	Seizure/Epilepsy
☐	☐	Dizziness/Vertigo
☐	☐	Multiple Sclerosis
☐	☐	Polio
☐	☐	Muscle weakness
☐	☐	Numbness
☐	☐	Pinched Nerve
☐	☐	Bowel/bladder dysfunction
☐	☐	Other_____

		RESPIRATORY
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Sleep Apnea
☐	☐	Shortness of breath

Past	Present	CARDIOVASCULAR
☐	☐	Heart Disease
☐	☐	Stroke
☐	☐	High/Low Blood Pressure
☐	☐	Abnormal EKG tests
☐	☐	Poor circulation
☐	☐	Varicose veins
☐	☐	Other_____

		MUSCULOSKELETAL
☐	☐	Osteoporosis
☐	☐	Osteoarthritis
☐	☐	Rheumatoid arthritis
☐	☐	Bursitis
☐	☐	Tendonitis
☐	☐	Neck Pain
☐	☐	Midback Pain
☐	☐	Low Back Pain
☐	☐	Scoliosis
☐	☐	Herniated disc
☐	☐	Spinal stenosis
☐	☐	Arm Pain
☐	☐	Shoulder/Elbow/Wrist/Hand Pain
☐	☐	Leg Pain
☐	☐	Hip/Knee/Ankle/Foot Pain
☐	☐	Gout
☐	☐	Lyme Disease
☐	☐	Other_____

☐ ☐ Other_____

Name_____ Date_____

Please check any condition or symptom you now have or have had in the past.

Past	Present	SKIN
☐	☐	Itching
☐	☐	Rashes
☐	☐	Psoriasis
☐	☐	Eczema
☐	☐	Other_____

		GASTROINTESTINAL
☐	☐	Heartburn/Reflux
☐	☐	Nausea/vomiting
☐	☐	Hepatitis
☐	☐	Irritable bowel syndrome
☐	☐	Constipation
☐	☐	Reoccurring diarrhea
☐	☐	Other_____

Past	Present	EYES,EARS,NOSE,THROAT
☐	☐	Change in vision
☐	☐	Eye pain
☐	☐	Glaucoma
☐	☐	Deafness/loss of hearing
☐	☐	Tinnitus/ringing in ears
☐	☐	Nose bleeds
☐	☐	Sinus problems
☐	☐	Jaw pain / TMJ
☐	☐	Thyroid disease
☐	☐	Difficulty swallowing
☐	☐	Other_____

		GENITOURINARY
☐	☐	Frequent urination
☐	☐	Painful urination
☐	☐	Blood in urine/change in color
☐	☐	Urinary tract infection
☐	☐	Other_____

Do you have any other significant health conditions not listed above?

_____

_____

FAMILY HEALTH HISTORY

(please list any known health problems)

Relation	Health Conditions (Age diagnosed)
>Mother	
>Father	
>	
>	
>	

Office Polices

Dr. Case and her staff are pleased to welcome you to our practice. We ae dedicated to providing you and your family high quality chiropractic care in a relaxed setting.
As a part of our continuing effort to care for your chiropractic health, we would like to share some information regarding our office policies and procedures. Your cooperation and understanding is very important to us.

Personal Injury or Automobile Accidents
Please inform the front desk if you are here due to either of the above.

Medicare
Medicare covers **ONLY** spinal manipulation. *Medicare does NOT cover exams, exercise rehabilitation, therapeutic modalities or maintenance.* Patients will be responsible for deductible, coinsurance or visits that exceed Medicare's guidelines pf "Medical Necessity".

Insurance Benefits
If you have insurance, we will be happy to obtain coverage information. Please note, this is not a GUARANTEE of coverage or benefits. It is your responsibility to check with your insurance carrier to see if you need to stay within network and or obtain referrals. We will gladly answer any questions relating to your treatment or insurance benefits. Most plans have deductibles and yearly maximums. Once eligibility, deductibles, coverage rates and maximums have been verified we will file your claim for you. Your deductible, coinsurance or copays are due at the time of treatment. If you do not have insurance, payment is due at the time services are rendered.

Appointments
When an appointment is made for you, it is your time reserved with Dr. Case. A 24 hour notice is requested if you need to cancel or reschedule an appointment. Please note, without adequate notice, a $25 broken appointment fee will be billed to your account. Please be on time for your appointment, failure to do so will not allow enough time for your planned treatment. As a courtesy to our next patient, should you show later than 15 minutes after your scheduled time we will need to reschedule.

Payment Options
Payment is expected at the time of service, excluding the estimated portion covered by insurance. We accept cash, credit or checks. There is a $30 FEE for any check returned from the bank.

Acknowledgement of Financial Policy
I have read the above financial policy and I understand and agree that I am financially responsible for service that I receive from Morris Spine & Sport which are not covered by my insurance.

I also authorize as assignment of benefits for Morris Spine & Sport to directly receive insurance payment for provided services and grant permission for Morris Spine & Sport to proceed with any appeals process directed toward my insurance carrier for any denied services that my physician has deemed medically necessary.

We appreciate you entrusting us with your chiropractic health.

Printed Name of Patient Signature of Patient Date

Authorization To Bill Health Insurance / Assignment of Benefits

I _____(print name) do by hereby give full permission and authorization

To 7Bear Services LLC DBA Morris Spine & Sport Chiropractic, to bill _____(name of insurance company) for services rendered by Morris Spine & Sport. I also agree to have any checks or payments made by said insurance company to be made payable and deliverable to:

Morris Spine and Sport
12 James St
Morristown, NJ 07960

By signing this document I also agree to the following statements below:

I understand that I am responsible for understanding information about my health insurance policy and providing such information to Morris Spine & Sport Chiropractic, for correct billing. I am also responsible to notify Morris Spine & Sport Chiropractic in case of any changes in my health insurance status - inclusive benefits and any information I receive relating to care I have or will receive in this office.

I understand that Morris Spine & Sport Chiropractic will be providing services and billing my health insurance for those services at various times during the course of my care at this office. I understand that ultimately I am responsible for all payment relating to any and all charges relating to treatment and services that I received at Morris Spine & Sport Chiropractic during my care. I also understand that my insurance company and related policy plan offer benefits for services provided at Morris Spine & Sport Chiropractic, but that such benefits do not necessarily guarantee payment for those services.

I understand that the policy for Morris Spine & Sport Chiropractic requires payment in full for all services rendered at the time of visit, unless other financial arrangements have been made. If my account is not paid within 90 days of the date of service and no other financial arrangements have been made, I will be responsible for all legal fees, collections agency fees, and any other expenses incurred collecting my account (normal charge is -33% in addition to your outstanding balance due in our office). I understand the above information and agree that my health history and related information was completed correctly to the best of my knowledge and understand that it is my responsibility to alert Morris Spine & Sport Chiropractic of change in my medical status or insurance coverage.

The undersigned does agree to observe and abide by all of the statements made above.

_____ _____

Patient's Signature Date

Patient Health Information Consent Form
(Notice of HIPAA Privacy Practices)

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

(Print Name) (Signature) (Date)

Morris Spine and Sport
12 James St
Morristown, NJ 07960
Phone: 973-285-0888 Fax: 973-539-7858
E-mail: info@morrisspineandsport.com Website: www.morrisspineandsport.com

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morris spine & sport
holistic. balanced. wellness.

Informed Consent to Chiropractic Adjustments and Soft Tissue Therapy

Doctors of Chiropractic who use manual therapies techniques are required to advise patients that there are or may be some risks associated with such treatment.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulations involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that , as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to : fractures, disc injures, strokes, dislocations, sprains, strains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications and I wish to rely on the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon facts then known, and is in mu best interest.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities, on myself (or on the patient named below whom I am legally responsible for) by the licensed doctor of chiropractic of the Morris Spine & Sport Chiropractic Center.

I, by my signature below, consent to the chiropractic treatments offered or recommended to me by the chiropractor. I intend this consent to apply to all my present and future chiropractic care.

Print name Signature Date

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst. Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY/AT -HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL -

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS WITH FRIENDS -

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS -

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED -

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

6. **LIFE -SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0	1	2	3	4	5	6	7	8	9	10
COMPLETELY ABLE TO FUNCTION										TOTALLY UNABLE TO FUNCTION

ADDITIONAL COMMENTS:

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____ Score _____ [60]

Fuerstein M. Multidisciplinary rehabilitation of occupational musculoskeletal disorders. LACC Chiro Rehab. Chicago: Session 1, 9/95