To be performed by clinic staff:

Height: _____ inches
Weight: _____ pounds
BP: ____ / ____
Pulse: _____

MORRISON CHIROPRACTIC, P.A.
Gentle, Effective, Quality, Chiropractic Care

Confidential Case History

Patient Type: ☐ **New Patient** ☐ **Existing Patient- New Injury/Episode**

Name:_____ Date of Birth:_____ Date: _____

Main Complaint: Where is your pain? _____

Indicate how you rate your pain intensity right now: (none) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

When did it start? Date: _____ **Is it from an Auto Accident?** ☐ Yes ☐ No **Work Related Injury?** ☐ Yes ☐ No

How did it start?_____

Circle/Check the following answers that apply to you:
The symptoms have been: ☐ off and on ☐ more frequent ☐ chronic but mild ☐ gradually appearing ☐ worsening;
over the past: ☐ ___ hours, ☐ ___ days, ☐ ___ weeks, ☐ ___ months, ☐ ___ years.

Pain is: ☐ constant (76-100%) ☐ freq. (51-75%) ☐ occas. (26-50%) ☐ intermittent (25% or less)?

How many times in the past have you had the same/similar issue?: ☐ 0, ☐ 1-2, ☐ 3-4, ☐ 5 or more

Each painful episode lasts how long (be specific)? _____

Episodes have occurred for the past: ☐ ___ hours, ☐ ___ days, ☐ ___ weeks, ☐ ___ months, ☐ ___ years

Pain is worst: ☐ in the morning, ☐ by midday, ☐ at the end of the day, ☐ at night, ☐ throughout the day, ☐ the same all day

Does the pain radiate to other parts of your body? ☐ Yes ☐ No If yes, where?_____

Quality of Pain: ☐ dull ☐ sharp ☐ throbbing ☐ burning ☐ deep ☐ aching
☐ tingling ☐ stabbing ☐ cramping ☐ numbness ☐ radiating

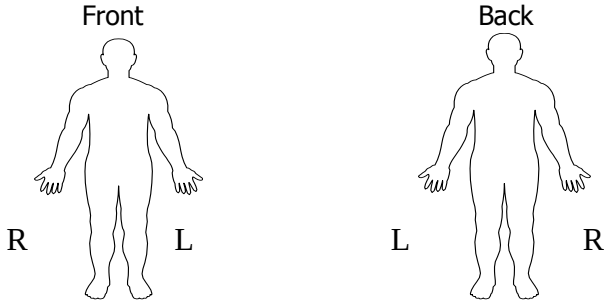
What makes your symptoms worse? ☐ sitting, ☐ standing, ☐ walking, ☐ bending, ☐ stooping, ☐ lifting, ☐ sleeping, ☐ sneezing, ☐ coughing, ☐ straining, ☐ reaching, ☐ twisting, ☐ looking up, ☐ looking down, ☐ movement, ☐ rest, ☐ lying on my back, ☐ driving, ☐ typing, ☐ house chores, ☐ exercise, ☐ lying on my stomach, ☐ stairs, ☐ Other: _____

What makes your symptoms better? ☐ sitting, ☐ standing, ☐ lying, ☐ knees bent up, ☐ support, ☐ no movement, ☐ movement, ☐ heat, ☐ ice, ☐ topical analgesic, ☐ ibuprofen, ☐ medication, ☐ rest, ☐ stretching/exercise, ☐ adjustments, ☐ Other: _____

Have there been other changes in any body functions? ☐ Yes ☐ No If yes, Explain:_____

Doctors seen/tests done for this condition: _____

Mark your areas of discomfort:



Name:_____ Date of Birth:_____ Date: _____

Are you experiencing/diagnosed with any of the following? Check yes or no.

	Yes	No
Cardiovascular		
Chest pain	☐	☐
Irregular, rapid or pounding heart beat	☐	☐
Swelling	☐	☐
Difficulty breathing/shortness of breath	☐	☐
History of heart disease	☐	☐
Respiratory		
Coughing/ Wheeze	☐	☐
Phlegm	☐	☐
Blood in sputum	☐	☐
Gastrointestinal		
Vomiting	☐	☐
Nausea	☐	☐
Heartburn	☐	☐
Bowel Incontinence	☐	☐
Blood in stool	☐	☐
Urogenital		
Painful urination	☐	☐
Increased urine frequency/urgency	☐	☐
Urinary Incontinence	☐	☐
Discharge/blood in urine	☐	☐
Musculoskeletal		
Joint pain/stiffness/weakness	☐	☐
Osteopenia/osteoporosis	☐	☐
History of whiplash	☐	☐
Recent fractures	☐	☐

	Yes	No
Psychosocial		
Depression/anxiety	☐	☐
Recent stressors	☐	☐
Change in lifestyle	☐	☐
Neurological		
Weakness: If yes, where: _____	☐	☐
Numbness: If yes, where:_____	☐	☐
Loss of sensation: If yes, where: _____	☐	☐
Dizziness/confusion/vertigo	☐	☐
Blurred vision/Double vision	☐	☐
Diminished/partial loss of vision	☐	☐
Slurred or difficult speech	☐	☐
Ringing in ears/ Hearing loss	☐	☐
Loss of consciousness/fainting	☐	☐
Headaches	☐	☐
Difficulty with taste/smell/swallowing	☐	☐
Fevers	☐	☐
Circulatory		
Bleeding problems	☐	☐
Swollen glands	☐	☐
Fluid retention/swelling	☐	☐
Hardening of the arteries	☐	☐
Blood vessel disease	☐	☐
Stroke/aneurysm	☐	☐
Take blood thinners	☐	☐

Are you under a doctor's care or been diagnosed with any other health problems? ☐ Yes ☐ No If yes, explain:___

_____

Have you been diagnosed with Hypertension presently? ☐ Yes ☐ No If yes, explain: _____

Have you been diagnosed with Diabetes presently? ☐ Yes ☐ No If yes, what kind? ☐ Type I ☐ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c> 9.0%? ☐ Yes ☐ No ☐ Not Sure

If yes, any other comments regarding Diabetes: _____

Have you had an X-ray, CT scan or MRI in the past 28 days? ☐ Yes ☐ No, If yes, of what? _____

Have you had any significant auto or work injuries or falls? ☐ Yes ☐ No When? _____

Are you taking any medications? ☐ Yes ☐ No If yes, Please list (include dosage): _____

_____

Have you had surgery? ☐ Yes ☐ No List type and date:_____

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former Smoker ☐ Never been a smoker

If yes, how often do you smoke? ☐ Current every day smoker ☐ Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

(no interest) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (very interested)

Do you have any allergies? ☐ Yes ☐ No. If yes, list:_____

Do any diseases run in your family? _____

My answers on this form are accurate to the best of my knowledge. I hereby consent to any procedures/ treatments necessary for treatment of any conditions as deemed reasonable by the attending doctor, and give my permission to obtain any records/reports from outside services related to this condition.

_____
Dr Initials/Date

Patient Signature:_____ Date:_____

Neck Disability Index Questionnaire

Name: _____DOB:_____Date: _____

This questionnaire has been designed to give your doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section with ONE answer that applies best to you. We realize you may consider that two of the statements in any one section relate to you; but please mark the answer that most clearly describes your problem.

Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Lifting

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift very light weights.
- ❑ I cannot lift or carry anything at all.

Headaches

- ❑ I have no headaches at all.
- ❑ I have slight headaches, which come infrequently.
- ❑ I have moderate headaches, which come infrequently.
- ❑ I have moderate headaches, which come frequently.
- ❑ I have severe headaches, which come frequently.
- ❑ I have headaches almost all of the time.

Personal Care (washing, dressing, etc.)

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need help every day in most aspects of self-care.
- ❑ I need some help every day in most aspects of self-care.
- ❑ I do not get dressed; I wash with difficulty and stay in bed.

Reading

- ❑ I can read as much as I want with no pain in my neck.
- ❑ I can read as much as I want with slight pain in my neck.
- ❑ I can read as much as I want with moderate pain in my neck.
- ❑ I can't read as much as I want because of moderate pain in my neck.
- ❑ I can hardly read at all because of severe pain in my neck.
- ❑ I cannot read at all because of severe pain in my neck.

Concentration

- ❑ I can concentrate fully when I want with no difficulty.
- ❑ I can concentrate fully when I want with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want.
- ❑ I have a lot of difficulty in concentrating when I want.
- ❑ I have a great deal of difficulty in concentrating when I want.
- ❑ I cannot concentrate at all.

Work

- ❑ I can do as much work as I want.
- ❑ I can only do my usual, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

Sleeping

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ❑ My sleep is mildly disturbed (1-2 hr's. sleepless).
- ❑ My sleep is moderately disturbed (2-3 hr's. sleepless).
- ❑ My sleep is greatly disturbed (3-5 hr's. sleepless).
- ❑ My sleep is completely disturbed (5-7hr's. sleepless).

Driving

- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as along as I want with slight pain in my neck.
- ❑ I can drive my car as long as I want with moderate pain in my neck.
- ❑ I can't drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe pain in my neck.
- ❑ I can't drive my car at all.

Recreation

- ❑ I am able to engage in all my recreational activities with no neck pain at all.
- ❑ I am able to engage in all my recreational activities with some pain in my neck.
- ❑ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- ❑ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ❑ I can hardly do any recreational activities because of pain in my neck.
- ❑ I can't do any recreational activities at all.

PCS-EN

Name:_____ Age:_____ Sex: M(__) F(__) Date:_____

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

0 – not at all **1** – to a slight degree **2** – to a moderate degree **3** – to a great degree **4** – all the time

When I'm in pain …

1_____ I worry all the time about whether the pain will end.

2_____ I feel I can't go on.

3_____ It's terrible and I think it's never going to get any better.

4_____ It's awful and I feel that it overwhelms me.

5_____ I feel I can't stand it anymore

6_____ I become afraid that the pain will get worse.

7_____ I keep thinking of other painful events.

8_____ I anxiously want the pain to go away.

9_____ I can't seem to keep it out of my mind.

10_____ I keep thinking about how much it hurts.

11_____I keeping thinking about how badly I want the pain to stop.

12_____There's nothing I can do to reduce the intensity of the pain

_____

… Total

Updated 11/11

MORRISON CHIROPRACTIC, P.A.
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Informed Consent

It is our responsibility to fully inform you of all aspects of your treatment. Part of this includes a discussion of any potential side effects or complications. All treatments potentially can cause these reactions, and chiropractic manipulation is no different. It however, has one of the ***safest*** records of the wide range of treatments that can be used for spinal disorders.

Possible adverse effects of spinal manipulation can include soreness in the area of treatment, reactive muscle spasm, injury to the disc causing pressure on nerve tissue, fractures in weakened bone such as ribs, and injury to arteries in the neck resulting in stroke. Soreness or reactive muscle spasm or tightening are common but usually brief in reactions to treatment. The other potential complications are rare. It is best to examine the frequency of these potential complications of the other typical treatments which may be used for a spinal disorder.

Disc injury from manipulation Causing spinal cord pressure	**Neurological complication from Neck Surgery**	**Back Surgery**
1 per 100 million	1 per 64	1 per 333

Artery Injury from manipulation Causing a stroke	**Death rate from neck surgery**
1 per 1 million	1 per 145

Perhaps the most common alternative to spinal manipulation is the use of anti-inflammatory drugs. These drugs cause fairly common and potentially serious complications.

Complications associated with anti-inflammatory drug use:

Serious stomach or intestinal bleeding	**1-4 per 1,000 users**
Hospitalizations from complications	**20,000 per year**
Deaths from complications	**16,500 per year**

I have read the above and understood the risk of complication that may occur from spinal manipulation. With this understanding, I consent to treatment with spinal manipulation by Morrison Chiropractic, P.A.

Name_____Signature_____Date_____

MORRISON CHIROPRACTIC, P.A.
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Payment Policy

Thank you for choosing our practice! We are committed to the success of your chiropractic treatment and care. Please understand that the payment of your bill is part of this treatment and care. For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies please speak with one of our Front Desk Associates.

How may I pay?

We accept payment by cash, check, all major credit cards, as well as online payments.

When is payment due?

Payment for all treatments, services, and products are due at the time of the visit.

How much do I owe?

Financial responsibility is determined by your insurance company. Insurance companies will NOT promise that any information given to our office regarding your coverage is correct nor is it a guarantee of payment. Each patient is responsible for monitoring changes with respect to any payout maximums and visit limits quoted by the insurance company.

Patient's signature: _____ Date: _____

Appointment Cancellation Policy

We understand that unplanned issues can arise in anyone's life and that due to these unexpected obligations you may need to cancel your appointment with our office. If this does happen, we respectfully ask that you cancel your scheduled appointments at least 24 hours in advance. Our doctors strive to be available for the needs of all of our patients. When an appointment is missed, or not cancelled within the requested time frame, another patient loses an opportunity to be seen.

Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments cancelled within 24 hours. Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

As of January 1st, 2015 the following charges will be applicable

$50 – for any new patient appointment that is missed or cancelled within 24 hours.

$30 – For any evaluation/examination appointment that is missed or cancelled within 24 hours.

$25 – For any treatment/maintenance appointment that is missed or cancelled within 24 hours

For all 1st offenses for cancelling/missing an appointment the fee will be waived.

Patient's signature: _____ Date: _____