



To be performed by clinic staff:

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

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

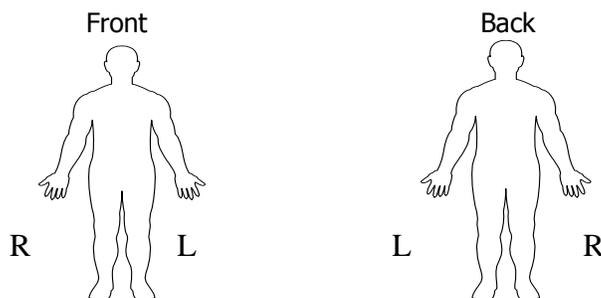
What makes your symptoms worse? [] sitting, [] standing, [] walking, [] bending, [] stooping, [] lifting, [] sleeping, [] sneezing, [] coughing, [] straining, [] reaching, [] twisting, [] looking up, [] looking down, [] movement, [] rest, [] lying on my back, [] driving, [] typing, [] house chores, [] 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 | | Yes | No |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Cardiovascular | | | Psychosocial | | |
| Chest pain | <input type="checkbox"/> | <input type="checkbox"/> | Depression/anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| Irregular, rapid or pounding heart beat | <input type="checkbox"/> | <input type="checkbox"/> | Recent stressors | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling | <input type="checkbox"/> | <input type="checkbox"/> | Change in lifestyle | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty breathing/shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | Neurological | | |
| History of heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Weakness: If yes, where: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory | | | Numbness: If yes, where: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Coughing/ Wheeze | <input type="checkbox"/> | <input type="checkbox"/> | Loss of sensation: If yes, where: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Phlegm | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/confusion/vertigo | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood in sputum | <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision/Double vision | <input type="checkbox"/> | <input type="checkbox"/> |
| Gastrointestinal | | | Diminished/partial loss of vision | <input type="checkbox"/> | <input type="checkbox"/> |
| Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | Slurred or difficult speech | <input type="checkbox"/> | <input type="checkbox"/> |
| Nausea | <input type="checkbox"/> | <input type="checkbox"/> | ringing in ears/ Hearing loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Heartburn | <input type="checkbox"/> | <input type="checkbox"/> | Loss of consciousness/fainting | <input type="checkbox"/> | <input type="checkbox"/> |
| Bowel Incontinence | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood in stool | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with taste/smell/swallowing | <input type="checkbox"/> | <input type="checkbox"/> |
| Urogenital | | | Fevers | <input type="checkbox"/> | <input type="checkbox"/> |
| Painful urination | <input type="checkbox"/> | <input type="checkbox"/> | Circulatory | | |
| Increased urine frequency/urgency | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Urinary Incontinence | <input type="checkbox"/> | <input type="checkbox"/> | Swollen glands | <input type="checkbox"/> | <input type="checkbox"/> |
| Discharge/blood in urine | <input type="checkbox"/> | <input type="checkbox"/> | Fluid retention/swelling | <input type="checkbox"/> | <input type="checkbox"/> |
| Musculoskeletal | | | Hardening of the arteries | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint pain/stiffness/weakness | <input type="checkbox"/> | <input type="checkbox"/> | Blood vessel disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteopenia/osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | Stroke/aneurysm | <input type="checkbox"/> | <input type="checkbox"/> |
| History of whiplash | <input type="checkbox"/> | <input type="checkbox"/> | Take blood thinners | <input type="checkbox"/> | <input type="checkbox"/> |
| Recent fractures | <input type="checkbox"/> | <input type="checkbox"/> | | | |

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: _____

Revised Oswestry Low Back Pain Questionnaire

Name: _____ DOB: _____ Date: _____

This questionnaire has been designed to give your doctor information on how your low back pain has affected your ability to manage everyday life. Please answer every section and mark in each section ONE answer that applies to you best. 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

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary.

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.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. 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 only lift very light weights at the most.

Sitting

- I can sit in any chair as long as I like without pain.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than one hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than ten minutes.
- Pain prevents me from sitting at all.

Personal Care (washing, dressing, etc.)

- I do not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain, but I manage not to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of pain, I am unable to do any washing and dressing with out help.

Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than ¼ mile.
- I can only walk while using a cane or on crutches.
- I am in bed most of the time and have to crawl to the toilet.

Standing

- I can stand as long as I want without pain.
- I have some pain while standing, but it does not increase with time.
- I cannot stand for longer than one hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than ten minutes without increasing pain.
- I avoid standing because it increases the pain straight away.

Sleeping

- I get no pain in bed.
- I get pain in bed, but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than one-quarter.
- Because of pain, my normal night's sleep is reduced by less than one-half.
- Because of pain, my normal night's sleep is reduced by less than three-quarters.
- Pain prevents me from sleeping at all.

Traveling

- I get no pain while traveling.
- I get some pain while I travel, but none of my usual forms of travel make it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling which compels me to seek alternate forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

Social Life

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of my pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- Pain has restricted my social life and I do not go out very much.
- I have hardly any social life because of pain.
- I can't drive my car at all because of the pain.

Changing Degree of Pain

- My pain is rapidly getting better.
- My pain fluctuates, but overall is definitely getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.

Roland Morris Disability Index

Name: _____ DOB: _____ Date: _____

When your back hurts, you may find it difficult to do some of the things you normally do. Check the box before each sentence that describes you today. Leave the box blank if the sentence does not describe you.

- I stay home most of the time because of my back.
- I change positions frequently to try to get my back comfortable.
- I walk more slowly than usual because of my back.
- Because of my back, I am not doing any of the jobs that I usually do around the house.
- Because of my back, I use a handrail to get upstairs.
- Because of my back, I lie down to rest more.
- Because of my back, I have to hold on to something to get out of an easy chair.
- Because of my back, I try to get other people to do things for me.
- I get dressed more slowly because of my back.
- I only stand up for short periods of time because of my back.
- Because of my back, I try not to bend or kneel.
- I find it difficult to get out of a chair because of my back.
- My back is painful almost all of the time.
- I find it difficult to turn over in bed because of my back.
- My appetite is not very good because of my back.
- I have trouble putting on my socks (stockings) because of my back.
- I only walk short distances because of my back pain.
- I sleep less well because of my back pain.
- Because of my back pain, I get dressed with help from someone else.
- I sit down for most of the day because of my back.
- I avoid heavy jobs around the house because of my back.
- Because of my back pain, I am more irritable and bad tempered with people than usual.
- Because of my back, I go upstairs more slowly than usual.
- I stay in bed most of the time because of my back.

PCS-EN

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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 keep thinking about how badly I want the pain to stop.
- 12____ There's nothing I can do to reduce the intensity of the pain
- 13____ I wonder whether something serious may happen.

... **Total**

Updated 11/11



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

1 per 100 million

Neurological complication from
Neck Surgery **Back Surgery**

1 per 64

1 per 333

Artery Injury from manipulation
Causing a stroke

1 per 1 million

Death rate from neck surgery

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 _____



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: _____