MORRISON CHIROPRACTIC, P.A.

**To be performed by clinic staff:**
**Height**: _____ inches
**Weight**: _____ pounds
**BP**: ____ / ____ **L/R**
**Pulse**: _____**Temp**: _____
**CA Initials:**_____

# Confidential Case History

**Patient Type:** ☐ **New Patient** ☐ **Existing Patient- Circle one: New injury or new episode**

Name:_____Date of Birth:_____ Date: _____

**Please send any reports or other communication to my primary care provider**: _____

**or other specialists I have seen:** _____.

**Main Complaint:** Where is your pain? _____

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

**How did it start?**_____

**What makes your symptoms worse?** moving from: ☐lay to sit ☐sit to stand ☐ascend stairs ☐bearing down/strain ☐bend ☐carry ☐cough/sneeze ☐cross legs ☐descend stairs ☐driving ☐exercise ☐lift; lying on: ☐back ☐stomach ☐L side ☐R side ☐reaching ☐ sitting ☐squatting ☐ standing, ☐ stoop ☐stress ☐turn in bed ☐twist ☐walking ☐look down ☐look up ☐reading, turn head ☐L ☐R. ☐Other: -

_____

**What makes your symptoms better?** ☐Chiropractic adjustment ☐analgesic ☐exercise ☐heat ☐lay with knees bent up ☐ice Laying on: ☐back ☐stomach, ☐medication ☐movement ☐muscle relaxant ☐no movement ☐NSAID ☐sit ☐stand ☐stretch ☐back brace/belt ☐TENS ☐topical analgesic (Biofreeze etc.) ☐ Other: _____

**Quality of Pain:** ☐aching ☐burning ☐cramping ☐deep ☐dull ☐numb ☐radiating ☐sharp ☐shooting ☐stabbing ☐stiffness ☐throbbing ☐tingling

**Indicate how you would rate your pain intensity on the following scale. Please circle one number each to indicate. "best", "worst", "average over past week": (none) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)**

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

**Pain is worst**: ☐ in the morning, ☐ by mid-day, ☐ end of the day, ☐ at night, ☐ morning and evening, ☐ the same all day

**Each painful episode lasts how many** ☐ __ minute(s) ☐__hour(s) ☐__ day(s) ☐__ week(s) ☐ __ month(s) ☐never stops.

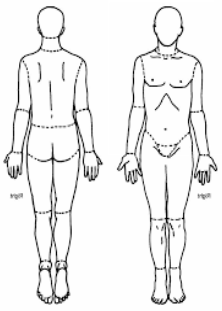
**What percent of your waking hours is the pain present?** ☐0 ☐10 ☐20 ☐30 ☐40 ☐50 ☐60 ☐70 ☐80 ☐90 100☐ %.

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

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

**Please list other providers, tests, treatment, procedures for this condition:** _____

**Mark your areas of discomfort:**



_____
Dr. Initials/Date

Name:_____ Date of Birth:_____ Date: _____

**Are you experiencing/diagnosed with any of the following?** Check Yes (Y) or No (N)

| | Y | N |
|---|---|---|
| **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 | ☐ | ☐ |

| | Y | N |
|---|---|---|
| **Psychosocial** | | |
| Depression/anxiety | ☐ | ☐ |
| Recent stressors | ☐ | ☐ |
| Change in lifestyle | ☐ | ☐ |
| **Neurological** | | |
| Weakness: If yes, where: _____ | ☐ | ☐ |
| Numbness: 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 currently under medical care?** ☐ Y ☐ N. **For what condition(s)?** _____

**Have you been diagnosed with any other health problems?** ☐ Y ☐ N. If Y, please explain: _____

_____

**Have you had any imaging (scans, x-ray etc) in the last 28 days?** ☐ Y ☐ N. If Y, what area? _____

**Have you had any significant auto or work injuries or falls?** ☐ Y ☐ N. If Y, when_____

**Are you taking any medications?** ☐ Y ☐ N. If Y, please list (include dosages): _____

_____

**Have you had surgery?** ☐ Y ☐ N. List type and date:_____

**Do you use/smoke tobacco?** ☐ Y ☐ N ☐ Former Smoker ☐ Quit date: _____ ☐ Never smoked ☐ Other form: _____

**Do you drink alcohol?** ☐ Y ☐ N ☐ #/week?____ **Recreational drug use?** ☐Y ☐ N ☐ Current ☐ Former. Type: _____

**Do you have any allergies?** ☐ Y ☐ N. If yes, list:_____

Mother: Alive and well? ☐Y ☐N Father: Alive and well? ☐Y ☐N _____

**Do any diseases run in your family?** Please list and family member affected_____

_____

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:_____

**Do you consent to communication regarding appointments, patient information, and your condition using an unencrypted/unsecure emailing service?**

**☐Yes ☐No** **Initials**: _____ **Patient Signature**: _____

# Bournemouth Questionnaire

## Back (BQ-back)

**Name:** **DOB:** **Date:**

*Please circle **ONE** number for each of the following statements that best describes your back pain and how it is affecting you **NOW**. Please read each question carefully before answering:*

| | |
|---|---|
| 1. Over the past few days, on average, how would you rate your back pain? | **No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Worst Possible Pain** |
| 2. Over the past few days, on average, how has your back pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving, sleeping)? | **No Interference** 0 1 2 3 4 5 6 7 8 9 10 **Unable to carry-on with normal day-to-day activities** |
| 3. Over the past few days, on average, how has your back pain interfered with your normal social routine including recreational, social, and family activities? | **No Interference** 0 1 2 3 4 5 6 7 8 9 10 **Unable to participate in any social and recreational activities** |
| 4. Over the past few days, on average, how anxious (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling? | **Not Anxious At All** 0 1 2 3 4 5 6 7 8 9 10 **Extremely Anxious** |
| 5. Over the past few days, on average, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, lethargic) have you been feeling? | **Not Depressed At All** 0 1 2 3 4 5 6 7 8 9 10 **Extremely Depressed** |
| 6. Over the past few days, how do you think your work (both inside the home and/or employed work) has affected your back pain? | **Makes It No Worse** 0 1 2 3 4 5 6 7 8 9 10 **Makes It Very Much Worse** |
| 7. Over the past few days, on average, how much have you been able to control (help/reduce) and cope with your back pain on your own? | **I Can Control My Pain Completely** 0 1 2 3 4 5 6 7 8 9 10 **I Have No Control Whatsoever** |

**THANK YOU VERY MUCH FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE**

Source: Bolton JE, Breen AC. The Bournemouth Questionnaire: a short-form comprehensive outcome measure. I. Psychometric properties in back pain patients. J Manipulative Physiol Ther 1999;22(8):503-10

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Name: _____ Primary Complaint: _____ Date: _____

1. Please indicate your usual level of pain during the past week.
No pain **0 1 2 3 4 5 6 7 8 9 10** Worst pain possible

2. Does pain, numbness, tingling or weakness extend into your leg (from low back) &/or arm (from neck)?
None of the time **0 1 2 3 4 5 6 7 8 9 10** All of the time

3. How would you rate your general health? (x-10)
Poor **0 1 2 3 4 5 6 7 8 9 10** Excellent

4. If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?
Delighted **0 1 2 3 4 5 6 7 8 9 10** Terrible

5. How anxious (eg. tense, irritable, fearful, difficulty in relaxing) you have been feeling during the past week:
Not at all **0 1 2 3 4 5 6 7 8 9 10** Extremely anxious

6. How much have you been able to control (i.e., reduce) your pain on your own during the past week:
I can reduce it **0 1 2 3 4 5 6 7 8 9 10** I can't reduce it at all

7. Please indicate how depressed (eg. down, sad, pessimistic) you have been feeling in the past week:
Not at all **0 1 2 3 4 5 6 7 8 9 10** Extremely depressed

8. On a scale of 0-10, how certain are you that you will be doing normal activities or working in six months?
Very certain **0 1 2 3 4 5 6 7 8 9 10** Not certain at all

9. I can do light housework for an hour.
Completely agree **0 1 2 3 4 5 6 7 8 9 10** Completely disagree

10. I can sleep at night.
Completely agree **0 1 2 3 4 5 6 7 8 9 10** Completely disagree

11. An increase in pain is an indication that I should stop what I'm doing until the pain decreases.
Completely disagree **0 1 2 3 4 5 6 7 8 9 10** Completely agree

12. Physical activity makes my pain worse
Completely disagree **0 1 2 3 4 5 6 7 8 9 10** Completely agree

13. I should not do my normal activities including work with my present pain
Completely disagree **0 1 2 3 4 5 6 7 8 9 10** Completely agree

MORRISON CHIROPRACTIC, P.A.

# 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.

# 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 unforeseen circumstances can arise and you may need to cancel your appointment with our office. Should you need to, 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.

**As of September 1st, 2017 there will be $50 charged for any appointment that is missed or cancelled within 24 hours.**

Thank you for your understanding and cooperation as we institute this policy. This will enable us to open otherwise unused appointments to better serve the needs of all patients.

Patient's signature: _____ Date: _____

MORRISON CHIROPRACTIC, P.A.

I, _____ give my approval for the following people to have access to my protected health information. The individuals listed may schedule appointments on my behalf, request copies of invoices/bills and medical records and may be advised of my future appointment dates and times.

Name:_____ D.O.B_____

Name:_____ D.O.B_____

Name: _____ D.O.B_____

I understand that it is my responsibility to notify Morrison Chiropractic if I need to make any changes to this form.

Printed Name:_____

Signature: _____

Date: _____