MORRISON CHIROPRACTIC, P.A.

Confidential Patient Information

Today's Date ____ , ____ , ____ **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____ **Suffix** _____

Primary Care Physician: _____

Who referred you to our office? _____

Patient Address _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____ **Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth ____ , ____ , ____ **Age** _____ **Sex** *(check one)* ❑ Male ❑ Female ❑ Unspecified

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ Asian Indian ❑ Chinese
❑ Japanese ❑ Korean ❑ Other:_____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Other: _____ ❑ I choose not to specify

Verification Question (this is used to confirm your identity if asking for health information over the phone)

(choose only one question by circling the question, then give the answer to that question)

❑ What is the name of your favorite pet? ❑ In what city were you born? ❑ What high school did you attend?
❑ What is your favorite movie? ❑ What is your mother's maiden name? ❑ On what street did you grow up?
❑ What was the make of your first car? ❑ When is your anniversary? ❑ What is your favorite color?

Verification Answer to the Chosen question: _____

Would you like to receive text notifications for appointments? : ❑ Yes ❑ No

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Confidential Case History

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

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.

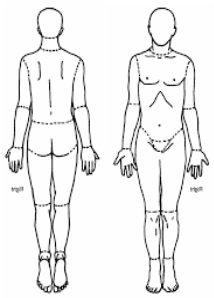
What percent of your waking hours is the pain present? ☐0 ☐10 ☐20 ☐30 ☐40 ☐50 ☐60 ☐70 ☐80 ☐90 100☐ %.

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:



_____

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.

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**: _____

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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.

PATIENT _____
DOB _____

AUTHORIZATION & ASSIGNMENT

This is to certify that I have engaged Morrison Chiropractic for professional services. I hereby authorize the following and will permit a photocopy to be considered as valid as the original, and may be used in lieu of the same.

AUTHORIZATION TO RELEASE INFORMATION

I authorize you to release any information you feel appropriate concerning my condition to any insurance company, attorney, or adjuster in order to receive reimbursement for any charges incurred by me as a result of services rendered by you professionally.

AUTHORIZATION TO PAY DIRECTLY TO DOCTOR

I authorize direct payment to you of any sum that I owe you now or in the future from any insurance company that is obligated to reimburse me for charges incurred in your office in part or full, or my attorney and other sources of benefits out of the proceeds of my settlement.

ASSIGNMENT OF CAUSE OF ACTION

I hereby assign and give you the right to take action against any insurance company that is obligated by contract to make payment to me. I authorize you to take action in either my name or your name to resolve this claim. It is understood that all reasonable efforts will be made to collect from the insurance company before I will be responsible for this bill. I do understand that whatever amounts are not collected from the insurance company will become my responsibility, and I am obligated to pay these charges upon receipt of a bill. I waive any claims arising under any statutes of limitations.

Patient Signature_____ Date_____
Guarantor Signature_____ Date_____

MORRISON CHIROPRACTIC, P.A.
2850 N. Ridge Rd., #107, Ellicott City, MD 21043 Phone: 410.465.0555
6363 Ten Oaks Rd., Clarksville, MD 21029 Phone: 410.531.9985

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Morrison Chiropractic, P.A. or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Please note treatment is commonly done on the exercise floor in an open area. Private rooms are always available to discuss your health information upon request.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

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: _____