



### 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



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.

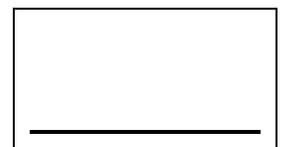
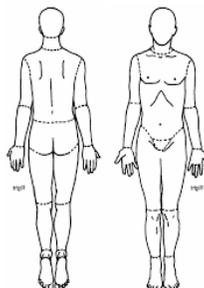
What percent of your waking hours is the pain present? [ ] 0 [ ] 10 [ ] 20 [ ] 30 [ ] 40 [ ] 50 [ ] 60 [ ] 70 [ ] 80 [ ] 90 100 [ ] %.

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		Y	N
<b>Cardiovascular</b>			<b>Psychosocial</b>		
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"/>	<b>Neurological</b>		
History of heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Weakness: If yes, where: _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory</b>			Numbness: If yes, where: _____	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/ Wheeze	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/confusion/vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision/Double vision	<input type="checkbox"/>	<input type="checkbox"/>
Blood in sputum	<input type="checkbox"/>	<input type="checkbox"/>	Diminished/partial loss of vision	<input type="checkbox"/>	<input type="checkbox"/>
<b>Gastrointestinal</b>			Slurred or difficult speech	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	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"/>
<b>Urogenital</b>			Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<b>Circulatory</b>		
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"/>
<b>Musculoskeletal</b>			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 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: \_\_\_\_\_

# Bournemouth Questionnaire

## Neck (BQ-neck)

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

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

**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

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



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  
6363 Ten Oaks Rd., Clarksville, MD 21029

Phone: 410.465.0555  
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



## **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**  
**Hospitalizations from complications**  
**Deaths from complications**

**1-4 per 1,000 users**  
**20,000 per year**  
**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 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 1<sup>st</sup>, 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: \_\_\_\_\_



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: \_\_\_\_\_