MORGAN ROAD CHIROPRACTIC AND PHYSICAL MEDICINE

PATIENT INFORMATION

Name you are called: _____

First Name: _____ M.I.: _____ Last Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home #: _____ Cell #: _____ Work #: _____

SS#: _____-_____-_____ Age: _____ DOB: __ __ /__ __ /__ __ Male / Female

Primary Care Physician: _____

Do we have permission to contact your doctor regarding your care in our office? Yes No

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Spouse's Name: _____ # of Children? _____ Children's Ages: _____

Emergency Contact Name: _____ Relation: _____ Phone #: _____

Smoking Status: Never smoked / Former Smoker / Occasional Smoker / Daily Smoker Preferred Language: _____

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer **Ethnicity (Circle one)**: Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

ACCIDENTS

Have you had an auto accident? (X if applies): ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Had a recent fall/other accident? (X if applies) : ☐ 0-6mo ☐ 6 mo-1 yr ☐ 1-3yrs ☐ 3+yrs ☐ Never

Have You Ever Received Physical Therapy ☐ Chiropractic Care ☐ or Pain Management ☐? Last Visit: _____

REFERRAL

How Did You Hear About This Office? _____

_____

INSURANCE

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release **Method of payment for today's charges: ___Cash ___Check ___Visa / MC**

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN PRACTICE, Morgan Road Chiropractic and Physical Medicine, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

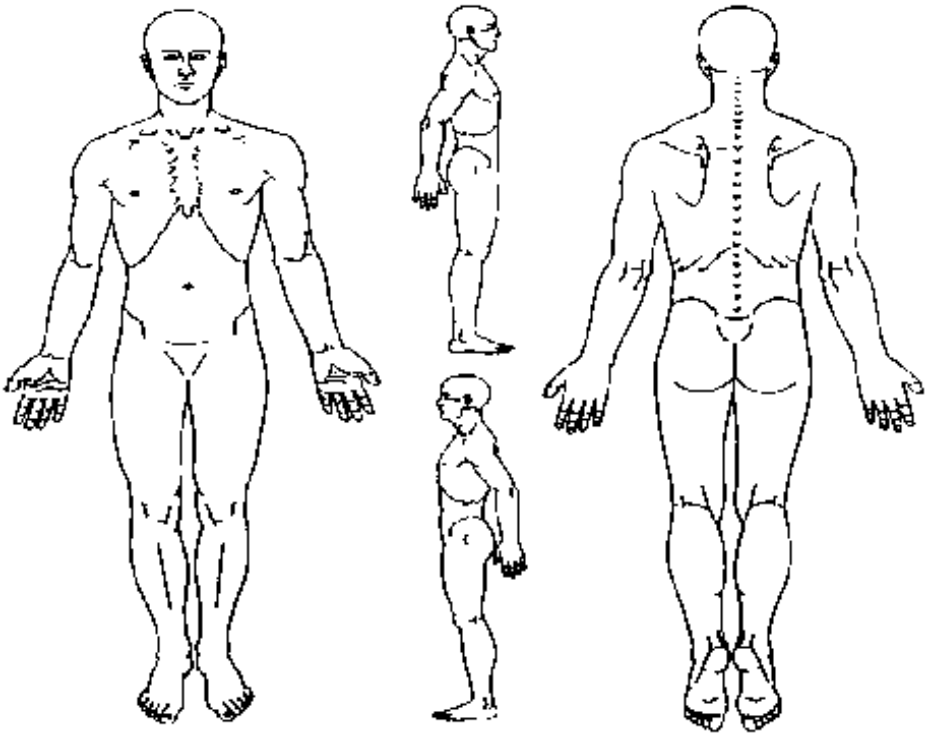
SIGNATURE (X) _____ **DATE** _____

PATIENT HEALTH COMPLAINTS

MOST SEVERE ◄——————————————————► LEAST SEVERE

What are your areas of pain or complaints? (WRITE-IN)	1.	2.	3.	4.
How long have you had this complaint?	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years	____ Days / Weeks / Months / Years
Describe how the problem began.				
What makes it better?				
What makes it worse?				
Circle the word(s) that best describes this complaint.	Dull Stabbing Sharp Throbbing Stiff Tingling Tight Numb Achy Shooting Burning	Dull Stabbing Sharp Throbbing Stiff Tingling Tight Numb Achy Shooting Burning	Dull Stabbing Sharp Throbbing Stiff Tingling Tight Numb Achy Shooting Burning	Dull Stabbing Sharp Throbbing Stiff Tingling Tight Numb Achy Shooting Burning
Does the discomfort radiate down your arms or legs? Describe				
Rate the discomfort you are feeling <u>now</u>.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Rate the discomfort you feel at <u>worst</u>.	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
How often do you feel this complaint?	Constant Daily Weekly Off-&-On	Constant Daily Weekly Off-&-On	Constant Daily Weekly Off-&-On	Constant Daily Weekly Off-&-On
Is it getting better, worse or the same?	Better Worse Same	Better Worse Same	Better Worse Same	Better Worse Same
How have you taken care of this in the past? Has that helped?				
Circle the ways this issue is affecting your life. *(all that apply)*	job children hobbies finances sports exercise walking standing bowels urinary fatigue irritability sleep productivity household chores	job children hobbies finances sports exercise walking standing bowels urinary fatigue irritability sleep productivity household chores	job children hobbies finances sports exercise walking standing bowels urinary fatigue irritability sleep productivity household chores	job children hobbies finances sports exercise walking standing bowels urinary fatigue irritability sleep productivity household chores

Please mark the problematic areas on the body diagram:



Name: _____

PATIENT HEALTH HISTORY

Please check if you are currently experiencing any of the following conditions:

- ❑ Neck Pain/Stiffness
- ❑ Back Pain/Stiffness
- ❑ Arm/Hand Pain
- ❑ Leg/Knee Pain
- ❑ Headaches
- ❑ Loss of Taste
- ❑ Nervousness
- ❑ Jaw Problems
- ❑ Loss of Smell
- ❑ Stomach Problems
- ❑ Blurred/Double Vision
- ❑ Mood Changes
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Light Bothers Eyes
- ❑ Recent Weight Change
- ❑ Loss of Memory
- ❑ Cold Extremities
- ❑ Sleeping Difficulties
- ❑ Bowel/Bladder Changes
- ❑ Constipation/Diarrhea
- ❑ Shortness of Breath
- ❑ Swollen Joints
- ❑ Trouble Concentrating
- ❑ Nausea
- ❑ Night Pain
- ❑ Fatigue
- ❑ Fever
- ❑ Tension
- ❑ Chest Pain
- ❑ Asthma
- ❑ Cold Sweats
- ❑ Dizziness
- ❑ Loss of Balance
- ❑ Fainting
- ❑ Foot Trouble

- ❑ ADD/ADHD
- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma/Wheezing
- ❑ Bad Breath/Taste
- ❑ Bleeding Disorders
- ❑ Blood Pressure, High
- ❑ Blood Pressure, Low
- ❑ Breast Lump
- ❑ Broken Bones
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Colon Issues
- ❑ Contacts/Glasses
- ❑ Depression
- ❑ Diabetes
- ❑ Dry Skin
- ❑ Ear Infections
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Fractures
- ❑ Gall Bladder
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heartburn
- ❑ Heart Attack
- ❑ Heart Issues
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herniated Disc
- ❑ Herpes
- ❑ High Cholesterol
- ❑ Hormone/Gland Issues
- ❑ Insomnia
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Measles
- ❑ Menopausal Issues
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Mouth Sores
- ❑ Bleeding Gums
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Nosebleeds
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Pinched Nerve
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Issues
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatoid Arthritis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Sexual Difficulty
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Issues
- ❑ TMJ Pain
- ❑ Tonsillitis
- ❑ Tremors
- ❑ Tuberculosis
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ _____
- ❑ _____

Name: _____

PATIENT HEALTH HISTORY CONTINUED

Are you currently under **medical care**? ❑ Yes ❑ No If yes, explain _____

_____

Please list any and all **medications** you are currently taking: _____

_____

_____

Please list any **surgeries and hospitalizations** you have had (type & date): _____

_____

_____

Please list any **supplements** you are currently taking (vitamins/herbs/minerals): _____

_____

_____

Is there a family history of any of the following conditions? *(indicate family member including parents, grandparents & siblings)*

❑ Heart Disease_____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____ ❑ Other _____

Do you exercise: ❑ 5-7x/week ❑ 3-4x/week ❑ 1-2x/week ❑ Occasionally ❑ None

Do your work or home activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Do you sleep on your: ❑ Back ❑ Side ❑ Stomach

What is your daily/weekly intake of the following:
Caffeine ____ cups/day

Alcohol ____ drinks/week

Cigarettes _____ packs/day

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health. I will give complete & accurate information during my exam.

Signature (X)_____ Date _____

_____

Name: _____

INFORMATION PERTAINING TO TERMS OF ACCEPTANCE AND CONSENT FOR CARE

The clinicians in this office will attempt to identify and diagnose any ailments you may have that may be corrected through physical medicine, chiropractic care and active/passive rehabilitation. If any condition or disease appears to be out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

Chiropractic is a science and art which concerns itself with the relationship between the spinal structure and the functional nervous system, as that relationship may affect the preservation and restoration of health. An adjustment is the specific application of forces to correct or reduce spinal misalignments and fixations. Adjustments are usually done by hand but may be performed by handheld instruments. Chiropractic care, like all forms of health care, offers considerable benefit but may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition and rarely fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one per one million to two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known these things which otherwise might not come to the attention of the physician (deformities, illnesses, etc).

Prior to receiving chiropractic care in this office, a health history and physical exam will be completed. These procedures are performed to assess your specific condition, your overall health and your spinal health. These procedures will assist us in determining if chiropractic care is needed or if any further examinations, studies or referrals are indicated.

All relevant findings will be reported to you along with a care plan prior to beginning care. The patient assumes all responsibility/liability if he or she does not report on health forms any past medical history, illnesses, medications or allergies. The doctor will not provide any health care that is contraindicated.

CONSENT FOR CARE

I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary and to the chiropractic care, including spinal adjustments, as reported following my examination. I acknowledge that no guarantees have been made to me concerning the results of care and treatment.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or not, by binding arbitration under the current malpractice terms which can be obtained by written request.

I also understand that the fee paid for treatment x-rays is for analysis only. The file itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There is a fee for copying of the xrays of $5.00.

I have read and I accept the terms above and understand them fully. I hereby give consent to the clinic to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at any time discontinue with the exam and/or x-rays or any treatment if I so choose.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

Signature (X)_____ Date _____

FOR MINORS: I, _____ being the parent or legal guardian of
_____,

Name: _____

(Print Guardian Name) *(Print Minor's Name)*
have read and fully understand the above terms of acceptance & grant permission for my child to receive treatment.

Signature (X)_____ Date _____

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Morgan Road Chiropractic & Physical Medicine, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, email address, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or discloser of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms
of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the Information that we use or disclose based on this privacy notice may be subject to re-discloser by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Name: _____

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: DR TANYA SIGVALDSON. If you would like further information about our privacy policies and practices please contact:
DR TANYA SIGVALDSON.

This notice is effective as of June 12, 2013. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Signature (X)_____Date _____