

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.

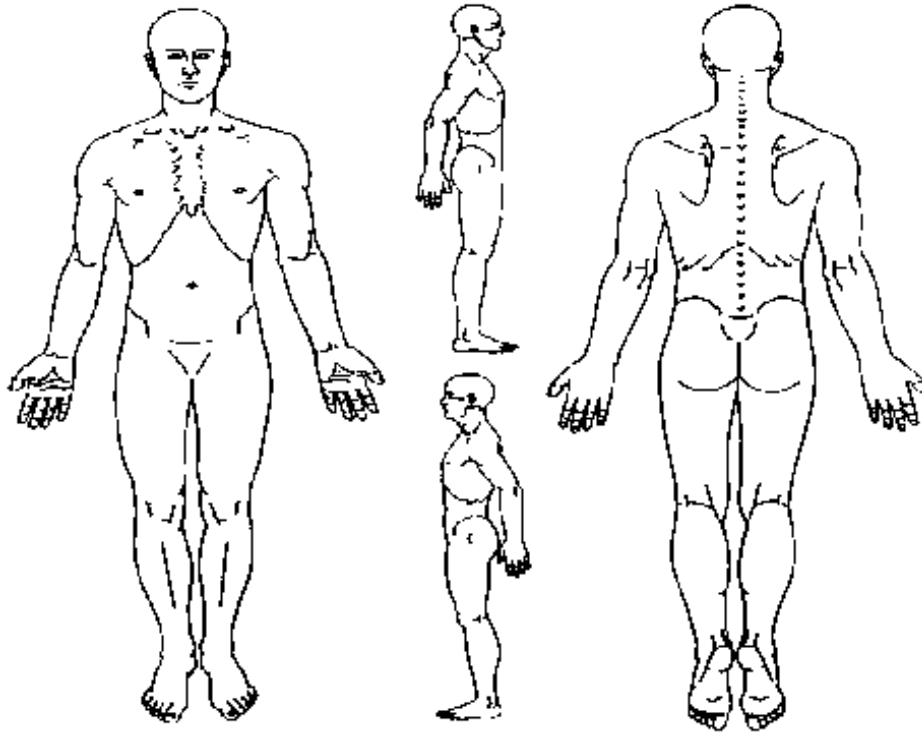
SIGNATURE (X) _____ **DATE** _____

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:

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

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

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 _____

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 film 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

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 _____
