NEW PATIENT INTAKE FORM

PATIENT DETAILS

Patient Name: ____ Date of Birth: ______________

Age: ___________________ Sex: ☐ Male ☐ Female ☐ Other: ______________

Address: ____

City: _________________________ State: _____________________ ZIP Code: ___________

Home Phone: _________________________ Mobile Phone: ___________________________

Work Phone: _____________________ E-Mail: ______________________________________

Preferred Contact Method: ☐ Home Phone ☐ Mobile Phone ☐ Work Phone ☐ E-Mail

Number of Children: ________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer (if any): _____________________________ Job Title: ________________________

Primary Physician: ____________________________

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

Have you been to a chiropractor before? ☐ Yes ☐ No

Emergency Contact Information

Emergency Contact Name: _____________________________ Phone:________________________

Relationship to Patient: ___________________________

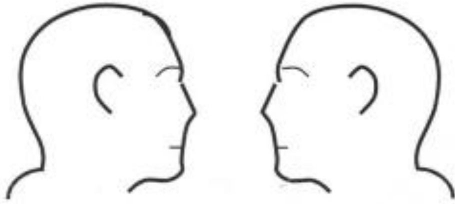
The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how Patient Health Information is going to use in this office and your rights concerning those records. The following person(s) has my permission to receive my personal health information.

Patient's Signature:____ Date:__________

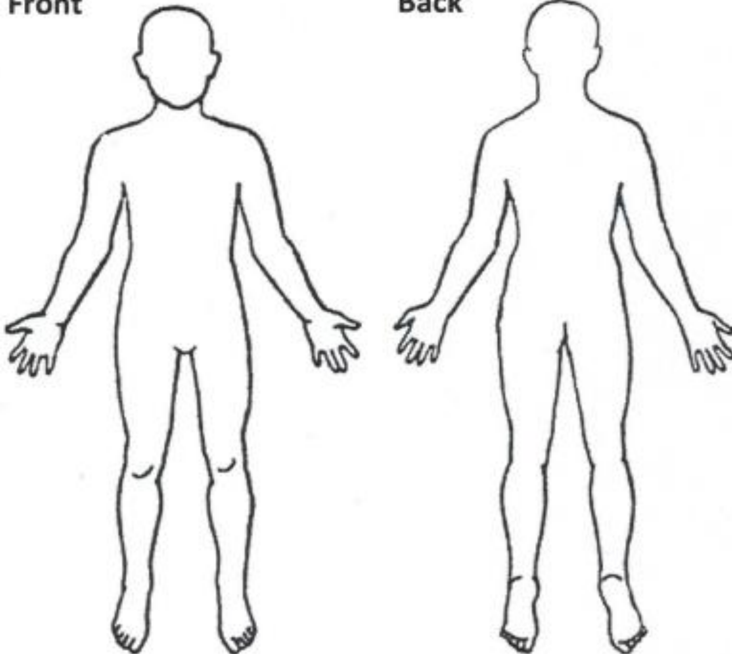
Guardian's Signature: ____Date: _________

SUBJECTIVE PAIN ASSESSMENT

Right Left



Front Back



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

FOR OFFICE USE ONLY:

L:	**Q:**
O:	**R:**
P:	**S:**
P:	**T:**

History of Present and Past Illness:

Chief Complaint: Purpose of this appointment: ____

Date symptoms appeared or accident happened: ______________________________________

Is this due to: ☐Auto ☐ Work Other_____________________________________

Have you ever had the same or a similar condition? ☐Yes ☐ No If yes, when and describe:

____

Days lost from work: _________ Seen by other provider for same issue? ☐Yes ☐ No

Do you have a history of stroke or high blood pressure? (Circle one, both, or neither)

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women please include information about childbirth. (Include dates) ____

____

Have you been treated for any health condition by a physician in the last year? ☐Yes ☐ No

If yes, please describe: ____

____

What medications or drugs are you taking? ____

____

Do you have any allergies of any kind? ☐Yes ☐ No

If yes, please describe: ____

Do you have any congenital condition? ☐Yes ☐ No If yes, describe: __________________

Women: Are you pregnant? ☐Yes ☐ No

Social History

Please indicate beside each activity whether you engage in it:

Often = O Sometimes = S Never = N

Exercise _____

High Stress Activity _____

Alcohol Use_____

Family Pressures _____

Tobacco _____

Financial Pressures _____

Drug Use _____

Other Mental Stresses _____

Have you had or do you have now any of the following symptoms/conditions? Please indicate with the letter **"C"** for current and **"P"** for previously in the box to the left of each item.

☐	Headaches Frequency of HA ________	☐	Anxiousness
☐	Neck Pain	☐	Fatigue
☐	Stiff Neck	☐	Depression
☐	Tension	☐	Ears Ring
☐	Back Pain	☐	Broken Bones/Fractures
☐	Muscle Spasms	☐	Rheumatoid Arthritis
☐	Shoulder/Neck/Arm Pain	☐	Excessive Bleeding
☐	Numbness in Fingers	☐	Pacemaker
☐	Numbness in Toes	☐	Hernia
☐	Weakness in Extremities	☐	Stroke
☐	Loss of Balance	☐	Eating Disorders
☐	Fainting	☐	Drug Addiction
☐	Dizziness	☐	Gall Bladder Problems
☐	Cold Hands	☐	Weight Loss/Gain
☐	Cold Feet	☐	Lights Bother Eyes
☐	Loss of Smell	☐	Loss of Memory
☐	Loss of Taste	☐	Circulation Problems
☐	Frequent Colds	☐	Seizures/Epilepsy
☐	Indigestion Problems	☐	Low Blood Pressure
☐	High Blood Pressure	☐	Osteoporosis
☐	Difficulty Urinating	☐	Heart Disease
☐	Menstrual Difficulties	☐	Cancer
☐	Unusual Bowel Patterns	☐	Coughing Blood
☐	Sleeping Problems	☐	Alcoholism
☐	Arthritis	☐	HIV Positive
☐	Irritability	☐	Ulcers
☐	Chest Pain/Tightness	☐	Sinus Problems
☐	Breathing Problems	☐	Diabetes
☐	Fever	☐	Joint Pain/Swelling
☐	Shingles	☐	Hysterectomy

Informed Consent

Clinic Name: Morrison Chiropractic

Doctor's Name: Blakely Morrison, DC

Address: 333 Main Street, Gainesville, MO 65655

Phone: (417) 989-0665

I will use my hands or a mechanical upon your body in such a way to move your joints. This procedure is referred to as a "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine or extremities are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications may include but are not limited to: muscle strain, cervical myelopathy, disc or vertebral injury, fractures, strains, dislocation, Bernard-Horner's syndrome, and costovertebral strains or separation. Rare complications include but are not limited to stroke. The most common complications or complaint following a spinal manipulation is an ache, stiffness, or soreness at the site of the adjustment.

I am aware of these complications and in order to minimize occurrence I will take precautions. These precautions include but are not limited to me taking of detailed clinical history and exam of you and examining you for any defect which could cause a complication of this examination. This may include the use of X-ray. The use of X-ray equipment may pose a risk if you're pregnant. If you are pregnant you should tell me when taking your clinical history.

Date: ____________________

____
Printed Name

____
Signature

What you can expect:
Thank you for choosing Morrison Chiropractic for your care. The following information covers our basic policy and information on what you can expect, payments, and appointments.

At your initial appointment Dr. Morrison will do a detailed examination, during which she will personally meet with you to discuss all of your needs and concerns. During the time of your examination, you will both discuss and establish a treatment plan just for you. Your treatment plan is going to determine how often you need to seek treatment in order to stay healthy and feel your best. We strongly encourage you to keep on your treatment plan so that you always feel your best. It is our goal to get you feeling back to your best self, often times meaning maintenance care after the initial treatment plan is completed.

We believe in open communication between doctor and patient. Do not hesitate to discuss questions and feedback on your care process with the doctor at your scheduled appointments.

Payment Policy:
Payments are due at the time of service. We are not in network with insurances. Payment Types: We take all major credit cards, debit cards, HSA cards, cash, or check. There is a $25.00 returned check fee if for some reason your check does not go through when we try to deposit it. **We cannot guarantee that your check will be deposited within the same week**.

Appointments:
We kindly ask that you give us 24-hour notice if you need to reschedule your appointment or are unable to make your appointment for any reason. You are subject to a $20 no call, no show (NCNS) fee. Missing three or more consecutive appointments without any contact, makes you subjective to being released from care at our clinic. You will receive reminder texts the day before your scheduled appointment.

Patient's Signature:____ Date:__________

Guardian's Signature: ____Date: _________