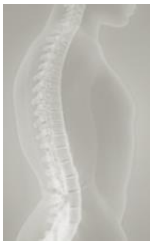


Welcome to Morris Chiropractic

helping you achieve optimum health through chiropractic care

Name _____ M / F Date of Birth ___/___/_____
(Please Print) First Middle Last

Address _____ City _____ State _____ Zip _____

Whom may we thank for referring you to us? _____

Home Phone # _____-_____-_____ Work Phone # _____-_____-_____ Cell Phone # _____-_____-_____

Preferred Phone to Contact ☐ Home ☐ Work ☐ Cell

Preferred Method of Contact ☐ Mail ☐ Phone ☐ Email _____

Your Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Person to contact in case of emergency _____ Phone # _____-_____-_____

Race – check one		Ethnicity – check one	Preferred Language
☐ American Indian / Alaska Native	☐ Pacific Islander	☐ Hispanic / Latino	☐ English
☐ Asian	☐ White	☐ Non-Hispanic / Latino	☐ German
☐ Black / African American	☐ Unreported / Refused to Report	☐ Unreported / Refused to Report	☐ Spanish
☐ More than one race			
☐ Native Hawaiian			

Insurance _____ Effective Date _____/_____/_____

Are you insured under another person?

If yes, Name _____ Date of Birth _____/_____/_____

Please note that to minimize your financial responsibility, it is important for you to update us on any change to your insurance.

If patient is a minor, the signature of the parent / legal guardian below certifies that he or she has the legal right to select and authorize health care services for this minor child and hereby authorizes Phillip J. Morris, DC to perform diagnostic tests and render chiropractic adjustments and other related treatment to the above named patient. This authorization extends to all other doctors and/or office staff member s and is intended to include radiographic examination at the doctor's discretion.

I authorize Phillip J. Morris, DC, and Morris Chiropractic PSC to release any information including the diagnosis and the records of my treatment and examinations rendered to me or my minor child to third party payors and/or health care practitioners for the purpose of payment for services rendered and/or coordination of care. I authorize my insurance company to pay any benefits due directly to Morris Chiropractic PSC. I understand that my insurance carrier may pay less than the actual bill for services and that all insurance benefits, copay amount and estimated financial responsibility quoted by Morris Chiropractic PSC is based on information provided by my insurance company and subject to the disclaimer "this is not a guarantee of benefits or coverage". I understand I am responsible for payment of all services rendered on my behalf including any balance designated as patient responsibility by my insurance which may include services denied for payment by my insurance. If signed by a parent or legal guardian, this authorization also applies to my dependents.

X _____ _____

Signature of Patient (or parent / legal guardian) Today's Date

Tell us about your health

Health History *(check only those conditions which are applicable)*

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergy Shots
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headache
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Schlerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ **Pacemaker**
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attemt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other _____

Date of last physical/medical exam _____/_____/_____ Primary Care Doctor _____

List any surgeries you have had and the dates which they occurred: _____

_____

Are you pregnant? Y / N / UNKNOWN Nursing? Y / N Last monthly period _____/_____/_____

Daily Habits

What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy

What do your daily work habits include (ie sitting, standing, light labor, heavy labor, computer work)

_____

How much alcohol do you consume on a weekly basis? _____ Do you smoke? Y / N _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Medications

Please list all medications you are taking, including dose and frequency

_____ _____

_____ _____

_____ _____

List any vitamins and nutritional supplements you are taking

_____ _____

_____ _____

_____ _____

List any allergies, especially drug allergies

_____ _____

_____ _____

_____ **Are you allergic to latex? Y / N**

Have you had chiropractic care in the past? Y / N

If yes, when? _____ For how long? _____

☐ For this condition ☐ For a different condition Result _____

Why did you stop seeing the chiropractor? _____

X _____ Print Name _____ _____ _____

Tell us about your condition

Symptoms and Injury History

Reason for today's visit _____

When did you first notice the symptoms _____

Where specifically is the problem located? _____

Is this problem the result of ☐ automobile accident ☐ work injury ☐ Other injury ☐ no known injury

Describe _____

Describe the onset of symptoms ☐ Sudden ☐ Gradual (over how long?) _____

☐ Have not experienced this before ☐ Have experienced this before (when?) _____

Type of pain ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling
☐ Other (describe) _____

Since the onset of symptoms, has pain gotten ☐ better or ☐ worse

What medical treatment have you already received for this condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other _____

What home treatment have you tried? ☐ Rest ☐ Ice ☐ Heat ☐ Other _____

Name and address of other doctor(s) who have treated you for this condition

_____ Date _____/_____/_____

_____ Date _____/_____/_____

_____ Date _____/_____/_____

Have you had any tests or imaging studies (x-rays, MRI, CT, etc) for this condition? If yes, please list facility and date

_____ Date _____/_____/_____

_____ Date _____/_____/_____

_____ Date _____/_____/_____

X _____ Print Name _____ _____ _____

Signature of Patient (or parent / legal guardian) Today's Date *Staff Initials*

For office use

Blood Pressure _____/_____ Pulse _____ Height _____ Weight _____ ☐ Smoking Cessation Counseling

Notes: _____

_____

_____

_____

_____

_____

MORRIS CHIROPRACTIC

PHILLIP J. MORRIS, D.C.
2815 Bardstown Road
Louisville, KY 40205
(502) 456-1771
Fax (502) 451-4484

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have the right to request a copy of the full Notice of Privacy Practices which provides a complete description of how my protected health information may be used and disclosed. I understand that I may request this at any time.

I understand that I have the following rights and privileges:
• The right to review that notice prior to signing this consent.
• The right to request restrictions as to how my protected health information and/or contact information may be used or disclosed for the purpose of treatment, payment or healthcare operations. I understand that if I restrict the use of my health information for any of these purposes, Morris Chiropractic, PSC will be unable to bill my insurance and I will be responsible for payment for services on the day they are rendered.

SPECIFIC AUTHORIZATIONS (please select one)

☐ I give permission to Morris Chiropractic, PSC to use my email address, physical address, phone number and clinical records to contact me with holiday cards and information about treatment alternatives or other health related information. Morris Chiropractic, PSC will never provide any patient data including name, address, email address or any other personal information to any third party for any purpose not necessary for medical treatment or payment for services rendered.

☐ I **DO NOT** give permission to Morris Chiropractic, PSC to use my information as described above.

_____ _____
Patient Signature (or Parent/Legal Guardian) Date

_____
Print Name

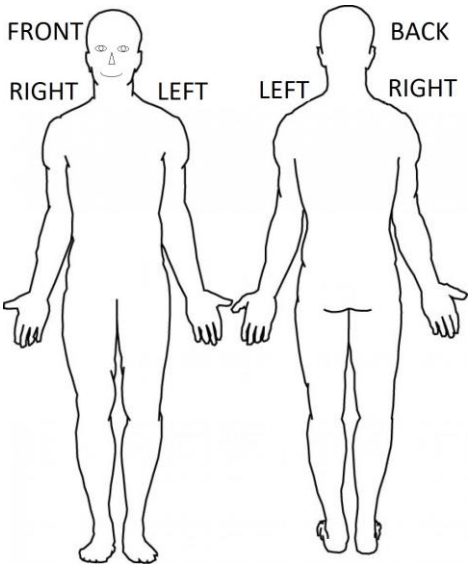
The next page contains a Functional Rating Index.

This form is used to provide help us assess your condition. This information is also used by your insurance company to determine how this condition affects your activities of daily living (work, sleep, etc).

Chiropractic care is typically covered by insurance until your condition improves to the point that it no longer affects your activities of daily living or until you are no longer experiencing improvement. Periodically throughout your treatment we will ask you to update this form. The information you provide will support the medical necessity of your treatment.

Our goal is to help you achieve optimum health through chiropractic care and get the most out of all your activities of daily living. This information will help us achieve that goal.

FUNCTIONAL RATING INDEX



MARK ALL AREAS THAT ARE CAUSING YOU PAIN OR DISCOMFORT

WHAT IS YOUR OVERALL PAIN LEVEL?

0 1 2 3 4 5 6 7 8 9 10

NO PAIN WORST POSSIBLE PAIN

In order to properly assess your condition, we must understand how your problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. PAIN INTENSITY

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Extreme pain

2. SLEEPING

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. PERSONAL CARE (washing, dressing, etc)

0	1	2	3	4
No pain	Mild pain, no restrictions	Need to go slowly	Need some assistance	Need 100% assistance

4. TRAVEL (driving, riding in care or on bus, etc)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. WORK (employment, housework, etc)

0	1	2	3	4
Can work + unlimited extra	Can do usual work, no extra	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. RECREATION

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. FREQUENCY OF PAIN

0	1	2	3	4
No pain	Pain 25% of the day	Pain 50% of the day	Pain 75% of the day	Pain 100% of the day

8. LIFTING

0	1	2	3	4
No pain	Increased pain with heavy weight	Increased pain w/mod-erate weight	Increased pain with light weight	Increased pain with any weight

9. WALKING

0	1	2	3	4
No pain, any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. STANDING

0	1	2	3	4
No pain	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

X **Name (please print)** _____ **Signature** _____ **Date** _____

Office Use Only

Treatment plan started on ____/____/_____ **Total Score** _____

# of visits this treatment plan _____ Date ____/____/_____ Score _____

GOAL: _____ Date ____/____/_____ Score _____

ADJUSTMENT: _____ Date ____/____/_____ Score _____

UPDATED TREATMENT PLAN: _____ **Previous TX Plan** _____