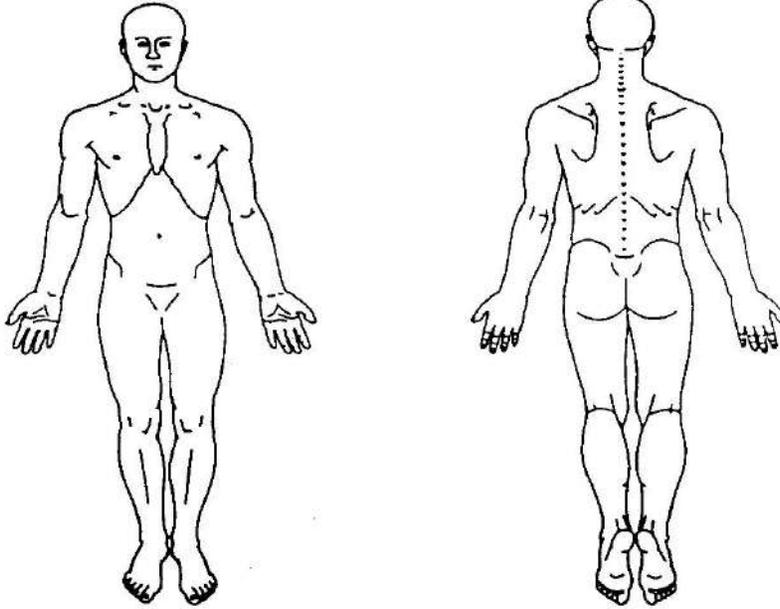


Name _____ DOB _____ Email _____

Address _____ Emergency Contact Name and # _____

INDICATE YOUR PROBLEM AREA USING THE FOLLOWING SYMBOLS

XXX = BURNING	//// = NUMBNESS
OOO = PAIN	ZZZ = TINGLING



List your chief complaints in order of importance.

List any serious illnesses suffered in the past - include year if possible.

List past physical traumas: sprains, fractures, falls, surgeries, car accidents with injury, scars (c-scar, episiotomy), hits to the head or body etc.

Do you use a heel lift or arch support? _____ Prosthetic or metallic implants? _____

Do you have dental implants, bridges, retainers or do you use a mouth splint or night guard?

Please put an X mark *only* in the boxes which describe current or past symptoms/conditions. Use the following capital letters to indicate the frequency.

O = Occasional F = Frequent C = Constant

O F C GENERAL	O F C GASTRO-INTESTINAL
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloating
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions or tremors	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult digestion
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Urination issues (pain, frequent)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive thirst or hunger
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sleep issues	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gallbladder or Liver
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sexual issues (pain etc.)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stomach pain
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Weight loss or gain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in stools
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Depression or anxiety	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting / lack of appetite
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive sweating	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Flatulence or burping

O F C CARDIO-VASCULAR/ RESPIRATORY	O F C SKIN
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood pressure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eczema/psoriasis
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High cholesterol	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Acne / boils
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor circulation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruise easily
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart palpitations / irregular beat	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dry skin
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen feet / ankles	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic coughing	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itchiness / numbness or tingling
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins

O F C EYE, EAR, NOSE THROAT	O F C FOR WOMEN ONLY
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mucus, phlegm	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful menstruation
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear pain	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive menstrual flow
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Buzzing / whistling in ears	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular cycles
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hearing loss	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nodes / lumps in breast
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye problems	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen / congested breasts
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen glands	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Urinary tract infections
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thyroid	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Symptoms of menopause
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat	Contraception Yes____ No_____

NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE)

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications:

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.

Ask us to limit what we use or share:

You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information:

You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

Choose someone to act for you:

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

Marketing purposes. Sale of your information. Sharing of psychotherapy notes.

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you:

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization:

We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services:

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research:

We can use or share your information for health research.

Comply with the law:

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:

We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions:

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice:

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

Patient Acknowledgement:

I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

Patient Printed Name

Patient Signature or legal representative

If legal representative, state relationship

Date

INFORMED CONSENT DOCUMENT

PATIENT NAME: _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. With your consent, I may use that procedure to treat you. I will use my hands in such a way as to move your joints. That may cause an audible “pop” or “click” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment.

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- muscle strength testing
- postural analysis
- spinal manipulative therapy
- palpations
- vital signs
- range of motion testing
- orthopedic testing (physical examination)
- basic neurological testing

Patient's signature: _____

The risks inherent in chiropractic adjustment.

As in any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injury, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributed to serious complications including stroke. Some patients will feel stiffness or soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The availability and nature of other treatment options.

Other treatment options for your condition may include

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above-noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

I hereby and authorize Dr. Robert Morrison to perform diagnostic tests and render chiropractic adjustments and other treatments to my minor son/daughter _____. This authorization also extends to all other doctors and office staff members and intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize other health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to so select or authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Robert Morrison and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Patient's name

Doctor's name

Signature

Signature

Rescheduling, Missed Appointments, Lateness:

Staying committed and keeping your appointments is critical for achieving maximum results.

If you need to cancel your appointment, please advise us within 48 hours (2 business days). By giving advanced notice we are able to give your appointment to someone else who is in need. If you cancel within less than 48 hours, you will be charged the fee for the appointment.

In addition, it is important to arrive on time for your visit in order to receive the best care. Please aim to arrive a few minutes early as there are often unexpected obstacles during travel.

I agree to the terms and conditions.

Print Name _____

Signature _____