



CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:		Name you go by:		Date:
Address:				
	Street	City	State	Zip
Home phone:		Work phone:		
Cell phone:		Email address:		
Best time/place to contact you:		In which Format do you prefer appointment reminders:		
		Phone Carrier: _____		
		Text Messages? <input type="checkbox"/> Email? <input type="checkbox"/> No Reminders? <input type="checkbox"/>		
Date of birth:		Age:		
No. of children:	Ages of Children:		Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Height:		Weight:		
Shoe Size:		Do you wear orthotics or heel lifts? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Marital status: M S W D		Spouse/guardian name:		
Occupation:		Full Time Part-Time Unemployed Retired		
Employer's name & address:				
Spouse's Occupation/Employer:				
Name of person responsible for account:				
Do you have insurance that covers Chiropractic care?		Do you have Medicare coverage?		
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>		

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

Health Concerns (Please Fill out all boxes as thoroughly as Possible for each concern)

Please list your health concerns according to their severity *Indicate Right, Left or Both Sides	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present?	Is Pain dull, sharp or radiating	Since the problem started is the pain the same, better or worse?	What makes it feel better or worse?
1.								
2.								
3.								
4.								

Are these conditions interfering with any of the following ?

Work <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily routine <input type="checkbox"/>	Sports/exercise <input type="checkbox"/>	Other <input type="checkbox"/> (please explain):
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What specifically would you like to be able to do that you cannot do right now? _____

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

Other doctors you have seen for these conditions:

Date last seen

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	<input type="checkbox"/>	
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)

- a. _____
 b. _____
 c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)

- d. _____
 e. _____
 f. _____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

- g. _____
 h. _____
 i. _____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):
 1 Being Low, 10 Being High

At work:	At home:	At play:
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On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Emotional health:
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General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any **surgery**? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or falls ? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If dietary changes are indicated would you be willing to make changes in your diet?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
Are you consuming the recommended 9-13 servings of Fruits and Vegetables Every Day?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Would you take whole food supplements if indicated?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If specific exercises or stretching would help would you consider adding them to your program?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If reducing stress would help you would you like to know ways to reduce stress?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>

Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times per week
M - Consume this monthly | **NO** - Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

Please mark the following conditions you may have had in the pas tor have now In the Past Now Have

<input type="checkbox"/> Alcoholism <input type="radio"/>	<input type="checkbox"/> Allergy <input type="radio"/>	<input type="checkbox"/> Anemia <input type="radio"/>	<input type="checkbox"/> Arteriosclerosis <input type="radio"/>	<input type="checkbox"/> Arthritis <input type="radio"/>	<input type="checkbox"/> Asthma <input type="radio"/>
<input type="checkbox"/> Back Pain <input type="radio"/>	<input type="checkbox"/> Cancer <input type="radio"/>	<input type="checkbox"/> Cold Sores <input type="radio"/>	<input type="checkbox"/> Constipation <input type="radio"/>	<input type="checkbox"/> Convulsions <input type="radio"/>	<input type="checkbox"/> Depression <input type="radio"/>
<input type="checkbox"/> Diabetes <input type="radio"/>	<input type="checkbox"/> Diarrhea <input type="radio"/>	<input type="checkbox"/> Eczema <input type="radio"/>	<input type="checkbox"/> Emphysema <input type="radio"/>	<input type="checkbox"/> Epilepsy <input type="radio"/>	<input type="checkbox"/> Gall Bladder Problems <input type="radio"/>
<input type="checkbox"/> Gout <input type="radio"/>	<input type="checkbox"/> Headaches <input type="radio"/>	<input type="checkbox"/> Heart Attack <input type="radio"/>	<input type="checkbox"/> Heart Disease <input type="radio"/>	<input type="checkbox"/> High Blood Pressure <input type="radio"/>	<input type="checkbox"/> HIV (Aids) <input type="radio"/>
<input type="checkbox"/> Irregular Periods <input type="radio"/>	<input type="checkbox"/> Low Blood Sugar <input type="radio"/>	<input type="checkbox"/> Malaria <input type="radio"/>	<input type="checkbox"/> Measles <input type="radio"/>	<input type="checkbox"/> Menstrual Cramps <input type="radio"/>	<input type="checkbox"/> Migraines <input type="radio"/>
<input type="checkbox"/> Miscarriage <input type="radio"/>	<input type="checkbox"/> Multiple Sclerosis <input type="radio"/>	<input type="checkbox"/> Mumps <input type="radio"/>	<input type="checkbox"/> Neck Pain <input type="radio"/>	<input type="checkbox"/> Nervousness <input type="radio"/>	<input type="checkbox"/> Neuritis <input type="radio"/>
<input type="checkbox"/> Pleurisy <input type="radio"/>	<input type="checkbox"/> Pneumonia <input type="radio"/>	<input type="checkbox"/> Polio <input type="radio"/>	<input type="checkbox"/> Rheumatic Fever <input type="radio"/>	<input type="checkbox"/> Ringing in ears <input type="radio"/>	<input type="checkbox"/> Sinus Problems <input type="radio"/>
<input type="checkbox"/> Stroke <input type="radio"/>	<input type="checkbox"/> Thyroid Problems <input type="radio"/>	<input type="checkbox"/> Tuberculosis <input type="radio"/>	<input type="checkbox"/> Ulcers <input type="radio"/>	<input type="checkbox"/> Venereal Disease <input type="radio"/>	<input type="checkbox"/> Whooping Cough <input type="radio"/>

Notice of Privacy Policy:

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- 1 You may request restrictions on your disclosures.
- 2 You may inspect and receive copies of your records within 30 days with a request.
- 3 You may request to view changes to your records.

In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff. I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- 3 Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- 4 Obtain payment from third party payers.
- 5 Conduct normal healthcare operation such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Signature: _____ **Date:** _____

Consent for Treatment

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

It is understood and agreed that the payments to the Doctor for x-rays is for examinations of x-rays only. The x-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

For ladies only: To my best knowledge I am not pregnant and know of no contraindications for x-rays at this time.
Date of my last menstrual period: _____

Print Patient Name:

Signature: _____ **Date:** _____

Staff Witness: _____ **Date:** _____

Authorization, Assignment, Acknowledgment and Understanding

AUTHORIZATION TO RELEASE INFORMATION: Morea Chiropractic Wellness Center is authorized to release any information that it deems appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Morea Chiropractic Wellness Center, including its designated associates and assistants and hereby release Morea Chiropractic Wellness Center from any consequence and/or liability concerning the same.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay directly to Morea Chiropractic any monies due it on account, the same to be deducted from any settlement made of my behalf. Further, it is understood and agreed that I shall pay the full amount of the charges, should my condition be such that it is not covered by my insurance policy or if for any reason the insurance company and/or attorney refuses and/or fails to pay my claim.

UNPAID INSURANCE BALANCE: I understand and agree that should there be any unpaid insurance balance for sixty (60) days, such balance shall automatically become my responsibility.

MEDICARE ASSIGNMENT: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I authorize a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

CONSENT TO CARE FOR A MINOR: I hereby authorize Morea Chiropractic Wellness Center to administer care as deemed necessary to: _____.

OBLIGATIONS AS TO SERVICES: I hereby acknowledge that I am receiving (or about to receive) health care services at Morea Chiropractic and that I have been advised that Morea Chiropractic is willing to wait for payment for these services so long as there continues to be a likelihood that payment will be made either by my insurance company and/or out of the settlement of my liability case.

I understand and agree that, in the event that:

- A. It is determined that there is no insurance company obligation to pay for Morea Chiropractic Chiropractic's services;
- B. The insurance company for the undersigned refuses to acknowledge an assignment to Morea Chiropractic or to take other actions for the protection of the interest of Morea Chiropractic;
- C. My attorney fails and/or refuses to agree to protect the interest of Morea Chiropractic as determined in its sole discretion; or
- D. I fail to retain an attorney

then payment of services at Morea Chiropractic will be made on a current basis and my bill paid in full within thirty (30) days from my last treatment.

INTEREST AND COLLECTION: I acknowledge and agree that, should my account become more than thirty (30) days overdue, I will incur interest on my past due balance of seven percent (7%) per annum. I further acknowledge and agree that Morea Chiropractic shall be entitled to reimbursement from me for any legal costs, including attorney fees, for all efforts to collect on any past due account with Morea Chiropractic Wellness Center.

By my signature below, I make the foregoing authorizations, assignments and agreements.

Patient Name (Please Print)

Patient Signature

Professional Courtesy

By my signature below, I request and authorize Morea Chiropractic to provide my medical doctor with a report for my medical record. Please send to:

Name of Medical Doctor

Office Name

Office Address

(_____) - _____
Telephone

Patient Name (Please Print)

Patient Signature