Northeast Chiropractic

Dr. Thomas C. Morison

Confidential Patient Information Form

Date_____ Patient File No_____

Name_____Age_____Date of Birth_____

Address_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Work Phone_____

Referred By_____ E-Mail address:_____

HEALTH GOALS

IT IS IMPORTANT to us that we know what your health goals are. Please check off the statement that most closely reflects your health goals.

( ) PATCH CARE: I only want to attempt pain relief.

( ) FIX TO AS NORMAL AS POSSIBLE: In addition to patch care, I want to attempt to fix my problem to as normal as possible.

( ) SPINAL CHECK-UP: I have no symptoms at present but want a spine and nervous system evaluation.

PERSONAL HEALTH HISTORY

What is your reason for visiting our office today?

_____

_____

_____

When was the first time you noticed this problem?_____

How did it originally occur? ( ) Work Related ( ) Motor Vehicle Accident ( ) Other_____

Has it become worse recently? ( ) Yes ( ) No ( ) Same

If yes, when and how?_____

How frequent is the condition? ( ) Hourly ( ) Daily ( ) Weekly ( ) Monthly

How long does it last? ( ) All day ( ) Few Hours ( ) Minutes ( ) Other_____

Describe the pain: ( )Sharp ( )Dull ( )Numbness ( )Tingling ( )Aching ( )Burning ( )Stabbing

Other:_____

Is there anything you can do to relieve the problem? ( ) Yes ( ) No

If yes, describe:_____

If no, what have you tried to do that did not help?_____

What makes the problem worse? ( )Standing ( )Sitting ( )Lying ( )Bending ( ) Twisting

Other:_____

PERSONAL HEALTH HISTORY

Name_____ Patient No_____

Have you had or do you now have any of the following conditions, which are or have been significantly distressful to you? Please indicate if you currently have this condition, or if you have ever had this condition in the past.

	Now	Past		Now	Past		Now	Past
Arthritis	_____	_____	Smoking	_____	_____	Motor Vehicle Accident	_____	_____
Asthma	_____	_____	Depression	_____	_____	Bone Fracture	_____	_____
Sinus Trouble	_____	_____	Loss of Taste	_____	_____	Loss of Memory	_____	_____
Allergies	_____	_____	Loss of Smell	_____	_____	Indigestion	_____	_____
Tuberculosis	_____	_____	Fainting	_____	_____	Scoliosis	_____	_____
Diabetes	_____	_____	Leg Cramps	_____	_____	Ear Infection	_____	_____
Epilepsy	_____	_____	Hemorrhoids	_____	_____	Sexually Transmitted Dx	_____	_____
Thyroid Trouble	_____	_____	Ears Ringing	_____	_____	Bruise Easily	_____	_____
HIV/AIDS	_____	_____	Cancer	_____	_____	Multiple Sclerosis	_____	_____
Emotional Difficulty	_____	_____	Prostate Trouble	_____	_____	Urinate Frequently	_____	_____
High Blood Pressure	_____	_____	Headache	_____	_____	Excessive Thirst	_____	_____
Urinary Tract Infxn	_____	_____	Skin Disorders	_____	_____	Unexplainable Weight Loss	_____	_____

Is there anything not listed here that you would like the doctor to know? _____

_____

Are you presently taking any medication? ( ) Yes ( ) No

If yes: ( )Anti-Inflammatory [Aspirin, Motrin, etc] ( )Pain Medication/Analgesics ( )Muscle Relaxants

( ) Cholesterol Lowering Drugs ( ) Other_____

Give dates and body region if you have had any of the following:

MRI_____ CT Scan_____ Ultra Sound_____

Broken Bones_____ Dislocations_____ Operations 1_____

Cosmetic Surgery(breast implants etc.)_____ 2_____

Surgery to replace hip, knee, etc._____ 3_____

Women only:

Date of last menstrual cycle_____ Date of last PAP Test_____

Painful Periods ( ) Irregular Flow ( ) C-Section ( )

Do you have any reason to believe you may be pregnant? ( )Yes ( ) No Due Date_____

FAMILY HEALTH HISTORY

Is there a family history of: ( )Heart Disease ( )Cancer ( )Diabetes ( )High Cholesterol ( )High Blood Pressure

( )Alzheimer's Disease ( )Multiple Sclerosis ( ) Stroke ( )Thyroid Problems

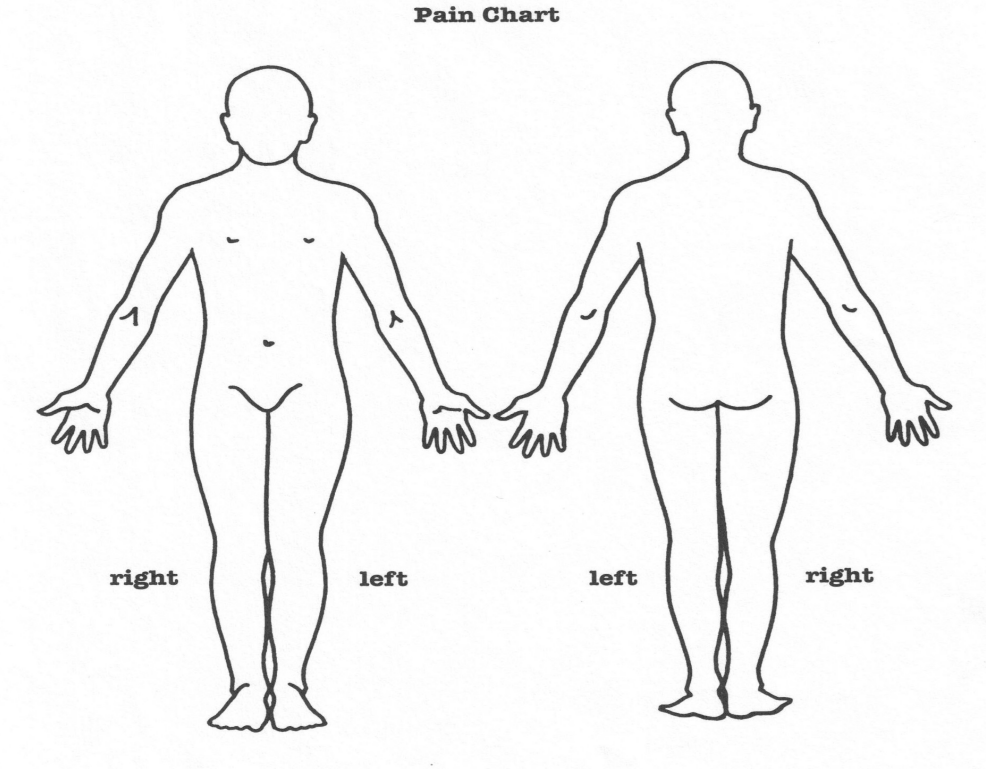
( )Other_____

Please list any other health condition(s) a family member may have that you would like to discuss with the doctor._____

Name_____ Patient File No._____

Mark the areas on the diagram where you are *currently* experiencing your symptoms. Use the appropriate symbols and mark areas affected.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-------	oooooooo	xxxxxxx	aaaaaaa	///////



Please mark on the pain scale, from Zero to 10 the pain you are *currently* experiencing (zero indicating that you have no pain and 10 indicating that you need to be in the hospital).

Neck-Shoulder-Arm Pain
On a scale of zero to 10, I rate my discomfort as follows

(_____)
0 10
No pain Severe pain

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows

(_____)
0 10
No pain Severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows

(_____)
0 10
No pain Severe pain

If you are not experiencing any discomfort, please check here _____

Date_____ Signature_____