Welcome to Optimum Natural Health Care At
Morris Chiropractic Clinic 210 Atlantic Avenue Morris, MN 56267

Patient Information

Thank you for choosing our practice for your natural health care needs. Please complete this form in black ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name____ Date_______________
Address___________________________City_______________ State_____ Zip __________
Date of Birth: ______________________ Age:______ Sex: ___Female ___Male
Marital Status: S M D W Social Security #______________________
Home Phone #:____________________ Work Phone #:___________________ Cell Phone #:____________________
Email Address:______________________________________ (for office announcements, email health update, monthly newsletter, other office information, birthday greetings, text appointment reminders & requests)
*Do we have your permission to contact you at any of your above listed phone numbers and email? Yes
If No, circle which phone number is best to
Patient Employer/School______________________________ Occupation_________________________
Spouse's or Parent's Name___________________________ Parent's Employer Work Phone #__________
Spouse Birthdate, if applicable:_____________
How were you referred to us? Patient (If patient, list name:____________________) Phone Book: Dex Federated Telephone
Yellow Book Internet Friend Doctor Other:_____________________
Person to contact in case of emergency:_________________________Relationship:____________
Home Phone #____________________ Work Phone#____________________ Cell Phone#:____________________

Insurance Information

Insurance Company Name:_______________________Name of Subscriber_______________ Relationship to patient_____________
Insurance ID#:____________________ Group #:________________Subscriber Birthdate___________________
DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE FILL IN THE INSURANCE CO. NAME, ID#, GROUP# & Insured's Name__________________________________

Responsible Party If same, check here: ( )
Name of person responsible for this account_______________________ Birthdate:________________
Relationship to patient____________________ Phone #: ( )________________
Address_______________________________ City____________ State___ Zip _______

Symptoms

Circle symptom(s) are you having today: **Neck Headache Shoulder(s) Upper Back Mid-Back Low Back Hip Arm Elbow Hand Knee Leg Ankle Foot Radiating Pain Other:**____________________
When did your symptom(s) begin?__________________ What do you think caused your symptom(s)?________________________
Circle the type(s) of Pain you're experiencing: **Constant Intermittent Frequent Aching Burning Cramping Dull Pins and Needles Pounding Sharp Stabbing Shooting Stiffness Throbbing Tingling Other:**______________
Circle and rate the severity of your pain: **Mild Mild to Moderate Moderate Moderate to Severe Severe**
Circle what makes your symptom(s) worse: **Bending Climbing Stairs Coughing Getting in & out of bed Driving Lying Down Lifting Pushing Pulling Sitting Sleeping Sneezing Standing Stress Walking**
Circle what make your symptom(s) better: **Cold Heat Reclining Sitting Standing Sleeping Taking Pain Pills**
Are your symptom(s) worse during certain times of the day? **Yes No** If Yes, when?_______________
Are your symptom(s) getting progressively worse? **Yes No Other:**____________________________
Do you ever experience ripping or tearing sensations in your back? **Yes No** If Yes, where:___________________________________
Do you have lower back pain which radiates into your abdomen? **Yes No**
Do have any problems with your bowel or bladder function? **Yes No**
Does it cause you pain to cough, grunt or sneeze? **Yes No**
What is your dominant hand? **Right Left**
Do you have any additional symptoms? **Yes No** If Yes, list here: ____
Your top health goals (circle): **Relieve Stress Improve Your Posture Improve Your Mood Improve Your Sleep Increased Mobility More Energy Improve Your Immune System Improve Your Digestion Overall Wellness**
What treatment have you already received for your condition? **Medication Physical Therapy Surgery None**
Are you taking any medications? Yes No If yes, list here:____
Name of other doctor(s) who have treated you for your symptom(s):____

Date of last (year): Physical Exam_________ Spinal Exam_________ Eye Exam_________ Dental Exam_________ Hearing Exam_________ Spinal X-Ray_________
Chest X-Ray_________ MRI_________ CT-Scan_________ Bone Scan_________

Accident Information
Are your symptom(s) due to an Accident? **Yes No** If Yes, when?:_________________
Type of accident: **Auto Work Home Other:**_________________________________
To whom have you made a report of your Accident? **Auto Insurance Agent Employer Workers Compensation**
Other:______________ **If Employer, who:**_____________

Health History
Circle if you have had any of the conditions listed below:
AIDS/HIV Arthritis Asthma Back Pain Cancer Depression Diabetes Dizziness Emphysema Epilepsy Glaucoma Headaches Heart Disease Hepatitis Hernia Herniated Disc Herpes Kidney Disease Liver Disease Loss of Balance Loss of Memory Migraine Headaches Multiple Sclerosis Neck Pain Osteoporosis Pacemaker Parkinson's Disease Polio Prostate Problems Prosthesis Psychiatric Care Rheumatic Fever Ringing in Ears Scarlet Fever Sleeping Problems Stroke Thyroid Problems Tuberculosis Venereal Disease Pins & Needles in Arms/Legs Numbness in Fingers/Toes Hands/Feet Cold Neck/Upper Back/Mid Back/Low Back Stiff Other____
Does anyone in your immediate family have a history of the symptoms you have today? Yes No If yes, list who:
____
(Women) Are you pregnant? **Yes No N/A** If Yes, Due Date:_________________
List any types of surgeries which you have had and the dates which they occurred:
____

Daily Habits
Do you exercise? **Yes No If Yes: Light Moderate Heavy Daily**
What do your daily work habits include? **Sitting Standing Light labor Heavy Labor Other:**_____________________________
Do you take nutritional supplements? **Yes No** If Yes, list:____
Do you take medication? **Yes No** If Yes, list:____
Are you allergic to any medication? **Yes No** If yes, list:____
Do you smoke? **Yes No** If yes, how much per day?_______________________
Do you drink liquor? **Yes No** If Yes, how much per week?________________
Do you drink coffee or caffeinated beverages? **Yes No** If Yes, how much per day?______________
Do you have stress? **Yes No** If Yes, circle choice(s): **Mild Mild to Moderate Moderate Moderate to Severe Severe**

Informed Consent, Certification and Release of Information
Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will gladly refer you to another provider who we feel can further assist you.
It is understood and agreed the amount paid the clinic for X-Rays's is for examination only and the X-Ray negatives will remain the property of this office, being on file where they may be seen upon request. Chiropractic, as well as other types of health care, is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkable safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Specific risk possibilities associated with chiropractic care: Soreness, Soft Tissue Injury, Rib Injury, Physical Therapy Burns, Stroke. While these are rare, they should be reported to your doctor promptly. Treatment is performed carefully to minimize such risks. If you have any questions concerning this form or the above statements, please ask your doctor.
I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Morris Chiropractic Clinic responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.
Having carefully read the above, I hereby authorize the physicians and staff at Morris Chiropractic Clinic to treat my condition as deemed appropriate. I also certify that no guarantee or assurance has been made to the results that may be obtained.

____
Signature of Patient, Parent, Legal Guardian or Personal Representative Date

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Printed Name of Patient, Parent, Legal Guardian or Personal Representative Date