**PATIENT INFORMATION UPDATE**

Name:_______________________________ Gender (circle): Male Female
Address:___________________________________ City, State, Zip Code:________________
Home Phone #:_________________________ Cell Phone #:__________________
Employer Name:______________________ Employer Phone #:_______________
Social Security Number:__________________ Birthdate:__________ Age:_____
Marital Status: S M W D Email Address:___________________________________
Spouse's Name:_____________________ Spouse's Birthdate:________________
Person responsible for this account: Self Other - Name:_________________________________
Insurance Co. Name:____________________ Policy Holder Name:_________________________________
Policy Holder Address:_____________________________________________ Policy Holder DOB:____________
In case of emergency, whom should we contact:_________________________
Phone #:_________________ Relationship to you:__________________
Is this Workman's Compensation Injury? Yes No Is this a Personal Injury? Yes No Is This a Auto Accident? Yes No

**HISTORY OF ILLNESS/INJURY/PAIN**
**CHIEF SYMPTOM(S):**
Chief symptom(s) and location:_____________________________________________________
What caused the onset?:___________________________________________________________
Date of onset?:______________________
**TIMING AND DURATION:**
How often do you experience this symptom(s)(circle)? Constant Frequent Intermittent Occasional Other:_______________
**SEVERITY:**
On a pain scale of 0 – 10, (with 0 representing no pain, 3 representing mild pain, 5 representing moderate pain, 8 representing severe pain and 10 being excruciating pain), rate the severity of your pain:_____________
**ASSOCIATED SIGNS AND SYMPTOMS:**
How does this symptom affect your movement (circle)?: Inflexibility Stiffness Spasms Cramping Other:___________________
**QUALITY:**
How would you best describe the sensation of the pain/symptom(s)? (check the ones that apply)
____Stabbing ___Burning ___Dull ___Prickly ___Hurting ___Shooting ___Sharp ___Numb ___Pulsating ___Throbbing
___Aching ___Crawling ___Pins & Needles ___Stinging ___Excruciating ___Tingling ___Pounding ___Deadness Sensation
**ASSOCIATED SIGNS & SYMPTOMS:**
If the pain/symptom radiates or travels, please identify where to on your body:__________________________

**MODIFYING FACTORS:**
What aggravates the pain/symptom(s)? (check all that apply)
___Flashing Lights ___Coughing ___Sneezing ___Standing ___Sitting ___Laying down ___Getting Out of Bed
___Carrying ___Pushing ___Pulling ___Straining at BM ___Lifting ___Stooping ___Stress ___Emotional Upset
___Climbing stairs ___Exercising ___Looking from side to side ___Looking up/down ___Driving ___Walking
___Repetitive Movement ___Getting in & out of car Other:___________________________________
What relieves the pain/symptom(s)?:
___Sitting ___Standing ___Laying down ___Sleeping ___Exercise/Movement ___Shower ___ChiropracticTreatment
___Mineral Ice ___Cold pack ___Warm Pack ___Pain pills i.e. Advil, Aspirin, Tylenol, ___Other:________________________
Over the past weeks/months is this pain/symptom(s): ___Getting Worse ___About the same ___Improving
Have you seen anyone for this condition? (circle) Yes No If yes, whom?:________________________
Do you have a pacemaker? Yes No Are you pregnant? Yes No N/A Do you think you may be pregnant? Yes No
Are you taking any medications? If Yes, list there:______________________________________________________________

**Authorization And Release**
I, the undersigned patient and/or legal guardian, authorize payment of insurance benefits directly to Morris Chiropractic Clinic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate.

Patient Signature:______________________________________ Date:_______________

Morris Chiropractic Clinic 210 Atlantic Avenue Morris, MN 56267