NEW PATIENT INFORMATION

1545 Mentor Avenue-Painesville, OH 44077
440-639-9171
info@morriswellness.com

Your appointment is scheduled for
Date_____
Time_____

~Welcome to Morris Chiropractic~

Please complete all questions and bring with you to your first visit.

The purpose of this office is to educate as many families as possible about the spinal condition known as *Vertebral Subluxation*. ***Vertebral Subluxation*** destroys an optimal spine and your ability to have Optimal Health. Your experience with this office will not only be of healing but also of learning the truth about **optimal health and healing.**

Name:	Today's Date:	
Address:		
City/State/Zip:		
Home Phone:	Work Phone:	Cell Phone:
Birth date:	Age:	Social Security #:
Marital Status: M W D S	Email Address:	
Your Employer:		Occupation:
Spouse's Name:		Spouse's Employer:
Children's Names & Ages:		
Your Favorite Hobbies:		
Who may we thank for referring you?		
When did you last see a chiropractor?		Dr.:
Are you here because of a recent auto or work injury?		Date of Accident:
Other Doctors you've seen recently:		
Medicines you take:		
Ever diagnosed with cancer?	What kind?	
Vitamins/Supplements you take:		
Surgeries you've had: (circle all that apply; write in others) hysterectomy, appendectomy, gall bladder, tonsils, c- section, cataracts, knee, hip, back		
Who is financially responsible for this bill?		
Method of payment: [ ] Cash [ ] Check [ ] Credit Card [ ] Insurance		
Emergency Contact:	Cell Phone:	Home Phone:
I, _____, authorize the following individuals to receive information about my health care and/or my account status:		
Name:	Phone Number:	Relation:

A. The vast majority of our patients have experienced dozens of impacts that could cause Vertebral Subluxations. Help us discover a few of yours.

1. How many total auto accidents have you been involved in? (Please Circle)
   5+ 3-4 1-2 0 Motorcycle accidents? Yes No

2. Which of the following sports have you been involved in? (Please Circle) football, basketball, soccer, field hockey, gymnastics, horseback riding, martial arts, rollerblading, other:_____

3. Have you ever…(please check) ☐ fallen down stairs ☐ slipped on ice or snow ☐ had a stress or strain while working ☐ sports injury

4. Do you… ☐ sit more than four hours per day ☐ drive more than two hours per day

5. Are you a… (please check) ☐ computer operator ☐ assembly line worker ☐ construction worker ☐truck driver ☐single or working parent ☐_____

B. **Subluxation** is when a bone moves and pushes on a nerve cutting off information to the brain. Subluxations can cause malfunction in any part of the body. Please check health complaints you are currently experiencing:

☐ Headaches	☐ Spinal Curvature	☐ Allergies	**Other**
☐ Neck Pain/ Shoulder Pain	☐ Sciatic Problems	☐ Sinus Problems	
☐ Upper/Mid Back	☐ Low Back Pain	☐ Asthma	
☐ Arm/Hand Problem	☐ Plantar Fasciitis	☐ Frequent Colds/Infections	
☐ Carpal Tunnel Syndrome	☐ Ear Infections	☐ Digestive Problems	

What activities would you like to do that your health is impairing you from doing? _____

_____

How would your life change if you had optimal health? _____

_____

What needs to happen in order for you to have optimal health and healing? _____

_____

1. All first visit charges are payable when services are rendered.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes they cannot be released.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Morris Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Morris Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment.

_____ _____

Patient's Signature Date

_____ _____

Guardian's Signature Authorizing Care for Minor Date

I have reviewed this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Brian J. Morris, D.C., Misty Morris, D.C., staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices. A personal copy can be made available upon my request.

Printed Patient Name _____ Date _____

Signature _____

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____