Source Chiropractic • 1716 Memorial Dr • Clarksville, TN 37191 • Tel: (931) 591-3740

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

Personal Information

Full Name: ______________________________
LAST *FIRST* *M.I.*

Address: ______________________________
STREET ADDRESS APT/UNIT #

____
CITY STATE ZIP CODE

Home Phone: ____________________ Cell phone: ____________________ Email: ____________________________

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Birthdate: _______/_______/_______ Social Security #: _______-_______-________

Emergency Contact: ______________________________ Emergency Contact Phone: ______________________

Payment/Insurance Information

Is the condition(s) that brought you here today due to an automobile accident or on the job injury?: ☐ Yes ☐ No

Who besides yourself is responsible for your bill? ☐ Self-Pay ☐ Health Insurance ☐ Medicare ☐ Medicaid

☐ Worker Comp ☐ Auto Insurance ☐ Other (*Be Specific*): ____

AUTO or WORKERS COMP Insurance Carrier & Claim #: ____

Health Insurance Information

Please present ALL Insurance Cards and picture ID to the front desk.

Are you the insured party? ☐ Yes ☐ No (If no please fill out the Policy Holder Information)

Policy Holder Information

Fill out only if Policy Holder is different from yourself.

Relationship to you: ____

Full Name: ______________________________
LAST *FIRST* *M.I.*

Address: ______________________________
STREET ADDRESS APT/UNIT #

____
CITY STATE ZIP CODE

Birth Date: _______/_______/_______ Social Security #: _______-_______-________

Responsible Party

Are you the Responsible Party? ☐ Yes ☐ No (If no, please fill out the Responsible Party Information)

Relationship to you: ____

Full Name: ______________________________
LAST *FIRST* *M.I.*

Address: ______________________________
STREET ADDRESS APT/UNIT #

____
CITY STATE ZIP CODE

Patient Name: ___________________________ DOB: ___/___/____ File #: __________________ Today's Date ___/___/_____

PRIMARY COMPLAINT

Describe the primary reason for your visit:

____

____

What do you think caused the problem? ____

When did your symptoms first begin? ______________________________ Was the onset: □ sudden □ gradual

Are the symptoms getting? □ Worse □ Better □ The same (relatively unchanged)

Have you previously had this condition? □ Yes □ No if yes, when? ____

Have you tried other medical treatments for this condition? □ Yes □ No If yes, what type:

Rate the pain from 1-10: At it's worst ____ At the present time ____ At least severe ___

Is your pain: □ Constant (76%-100%) □ Frequent (51%-75%) □ Intermittent (26%-50%) □ Occasional (0%-25%)

Does your pain travel? ☐ Yes ☐ No If yes, from where to where? ____

What activities are ***aggravated*** by your discomfort? (select one or more)

□ Bending □ Bowel Movements □ Coughing □ Daily Routine □ Driving □ Lifting □ Lying down
□ Sitting □ Sleeping □ Standing □ Urination □ Walking □ Working
□ Other (please describe): ____

What helps ***relieve*** your discomfort? (select one or more)

□ Ice □ Heat □ Medication □ Nothing helps □ Other: ____

SECOND COMPLAINT (If you have more than two complaints, please list them on the back of this sheet)

Describe the primary reason for your visit:

____

____

What do you think caused the problem? ____

When did your symptoms first begin? ______________________________ Was the onset: □ sudden □ gradual

Have you previously had this condition? □ Yes □ No if yes, when? ____

Have you tried other medical treatments for this condition? □ Yes □ No If yes, what type:

Rate the pain from 1-10: At it's worst ____ At the present time ____ At least severe ___

Is your pain: □ Constant (76%-100%) □ Frequent (51%-75%) □ Intermittent (26%-50%) □ Occasional (0%-25%)

Are the symptoms getting? □ Worse □ Better □ The same (relatively unchanged)

Does your pain travel? ☐ Yes ☐ No If yes, from where to where? ____

What activities are ***aggravated*** by your discomfort? (select one or more)

□ Bending □ Bowel Movements □ Coughing □ Daily Routine □ Driving □ Lifting □ Lying down
□ Sitting □ Sleeping □ Standing □ Urination □ Walking □ Working
□ Other (please describe): ____

What helps ***relieve*** your discomfort? (select one or more)

□ Ice □ Heat □ Medication □ Nothing helps □ Other: ____

Is there any other information that you feel would be relevant to your current condition(s) that was not covered? □ Yes □ No

Please explain:

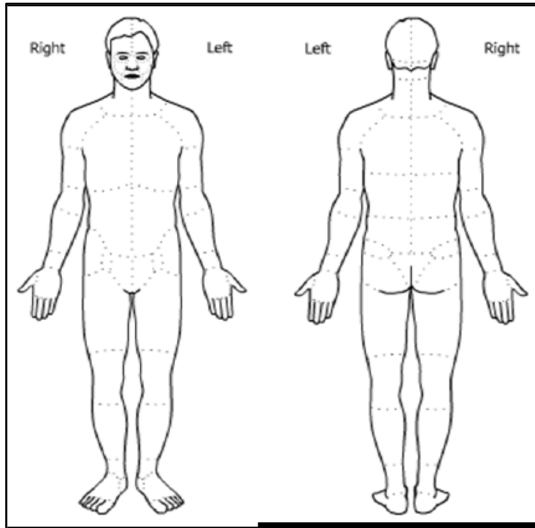
Please help us fully understand your symptoms. Identify your areas of discomfort with circles using the illustration to the right and creating a description of the effected body part(s) below. An example is listed for your convenience. For any questions regarding this form our staff would be happy to assist you.

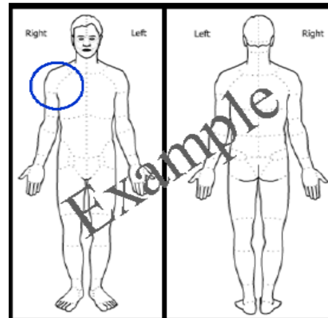
What is impacted by your current condition?

- ☐ Activities of daily living (*cleaning, bathing, etc)*
- ☐ Relationships (*impatience, irritability, motivation)*
- ☐ Work
- ☐ Sports or fitness
- ☐ Other:_______________________________

What are your goals for care?

- ☐ **Relief Care:** Symptomatic relief of pain or discomfort.
- ☐ **Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms.
- ☐ **Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care.
- ☐ **I want the doctor to select the type of care appropriate for my condition**





		Effected Body Part	Burning	Dull Ache	Sharp Stabbing	Throbbing	Numbness	Pins and Needles	Spasm	Swelling	Stiffness											
Example	L X (R)	*Shoulder*			X			X				Severity of Pain	1	2	3	4	5	6	X (7)	8	9	10
	L R											Severity of Pain	1	2	3	4	5	6	7	8	9	10
	L R											Severity of Pain	1	2	3	4	5	6	7	8	9	10
	L R											Severity of Pain	1	2	3	4	5	6	7	8	9	10
	L R											Severity of Pain	1	2	3	4	5	6	7	8	9	10

Health History Form

Height: ______ Weight: ______

Where applicable, specify the approximate date of you most recent: (month/year)

Spinal x-ray: _____/_____ CT scan: _____/_____
MRI: _____/_____ Other scans or x-rays: _____/_____

Medications taken on a regular or ongoing basis: Prescription, Over the Counter, Vitamins
____

____

Diet and Exercise

How much do you smoke? ☐ Less than one pack/week ☐ 1-2 packs/week ☐ 1 pack every two days
☐ 1 pack/ day ☐ More than 1 pack/ day ☐ None

How many alcoholic beverages do you consume per week? __________
Do you exercise regularly? ☐ Yes ☐ No If yes, how many days do you exercise each week? __________

Allergies ☐ None

Has a physician ever diagnosed you with Allergies, if so please specify what type: ________________________________
____

Cancer History ☐ None

Check if a physician has ever diagnosed you with any of the following cancers:
Check all that apply:

☐ Bladder ☐ Brain ☐ Breast ☐ Cervical ☐ Colon or Rectal ☐ Endometrial
☐ Eye ☐ Kidney ☐ Leukemia ☐ Lung ☐ Non-Hodgkin's Lymphoma
☐ Ovarian ☐ Pancreatic ☐ Prostate ☐ Skin – type: ______________________________________
☐ Stomach ☐ Thyroid ☐ Uterine
☐ Other: ____

Have any of your immediate family members have or had any of the above types or any other form of cancer:
(please describe)____

Cardio-pulmonary/Circulatory Health History ☐ None

☐ Anemia ☐ HIV/AIDS ☐Hemophilia ☐Hepatitis
☐ Stroke ☐ Raynaud's ☐Sinus Infections ☐ Hemorrhoids
☐ Wegener's Granulomatosis ☐Hypertension (high blood pressure) ☐ Hypotension (low blood pressure)
☐ Lung Disorders, please list: ____

Have any of your family members have or had any of the above conditions: (please describe)______________________
____

Endocrine – Gastrointestinal ☐ None

☐ Bladder Disease ☐ Chicken Pox ☐Crohn's Disease ☐ Epilepsy ☐ Gall Bladder Problems
☐ Incontinence ☐ Mumps ☐ Kidney Disease ☐ Shingles ☐ Thyroid Dysfunction
☐ Liver Disease ☐ Candida ☐ Fibromyalgia ☐ Diabetes ☐ Chronic Fatigue Syndrome
☐ Measles ☐ Seizures ☐ Stomach Ulcers ☐ Irritable Bowel Syndrome (IBS)
☐ Headaches:
☐ Cluster ☐Tension ☐ Migraine ☐ Stress induced ☐ Sinus
☐ Autoimmune Disorders:
☐ Lupus ☐ Rheumatoid arthritis ☐ Scleroderma ☐Sjogren's Syndrome
☐ Other: ____

Neurological Health History ☐ None

Check if a physician has ever diagnosed you with any of the emotional or mental conditions:

☐ Anger Disorders ☐ Anxiety ☐ Asperger Syndrome ☐ Attention Deficit Disorder with Hyperactivity (ADHD)
☐ Autism ☐ Bipolar ☐ Eating Disorders ☐ Borderline Personality Disorder
☐ Depression ☐ Narcolepsy ☐ Mood Disorders ☐ Obsessive Compulsive Disorder
☐ Phobias ☐ Suicidal ☐ Schizophrenia ☐ Restless Leg Syndrome
☐ Other: ____

Sensory Health History ☐ None

Check if a physician has ever diagnosed you with any of the following:

☐ Blindness ☐ Cataract ☐ Cholesteatoma ☐ Deafness or Hearing loss ☐ Ear ringing
☐ Eczema ☐ Glaucoma ☐ Laryngitis ☐ Macular Degeneration ☐ Mumps
☐ Psoriasis ☐ Rhinitis ☐ Nasal Polyps ☐Meniere's Disease ☐ Sinusitis
☐ Vertigo ☐ Perforated Eardrum ☐ Unusual Vision Impairment
☐ Other: ____

Musculoskeletal Health History ☐ None

Check if a physician has ever diagnosed you with any of the following:

☐ Gout ☐ Herniated Disc ☐ Lyme Disease ☐ Multiple Sclerosis ☐ Muscular Dystrophy
☐ Polio ☐Osteoporosis ☐ Rheumatism ☐ Pinched Nerve ☐Parkinson's Disease
☐ Sciatica ☐ Temporomandibular Joint Disease (TMJ)
☐ Numbness or tingling in hands ☐ Numbness or tingling in feet
☐ Arthritis, please specify which type: ____
☐ Other: ____

Surgical History ☐ None

Please list any surgeries with dates: ____

Reproductive Health History ☐ None

Check if a physician has ever diagnosed you with any of the following:

☐ Chlamydia ☐ Dysplasia ☐ Erectile Dysfunction ☐ Genital Herpes ☐ Human Papillomavirus (HPV)
☐ Syphilis ☐ Infertility ☐ Cystitis ☐ Prostate Enlargement
☐ Gonorrhea ☐ Menopause ☐ Vaginal Yeast Infection ☐ Uterine Fibroid ☐ Testicular Dysfunction
☐ Other: ____

Females Only:

Date of last menstrual period: _______/_______/_______

How many births vaginally? _______ How many births by C-section? _______

Please list any other concerns you may have concerning your health: ____

____

____

________________________________ ________________________________ _____/_____/______

PATIENT SIGNATURE **PATIENT PRINTED NAME** **DATE**

FOR OFFICE USE ONLY:

I have reviewed the above ROS with the above named patient: ____________________________ _________

Doctor Signature Date

Source Chiropractic • 1716 Memorial Dr • Clarksville, TN 37191 • Tel: (931) 591-3740

OFFICE FINANCIAL POLICY

Source Chiropractic is happy to work with our patients to provide the best quality of services. Please read the following. If you have health insurance, we will do our best to help you receive maximum benefits. Insurance is a contract between you and your insurance company. We are not a party to this contract. When possible, we will call your insurance company to verify your benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Our office will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other that supply factual information as necessary. You are responsible for the items listed above as well as any services considered "not medically necessary" by your insurance company. We participate with most insurance companies; however, if we do not participate with your insurance company, you are responsible for all out of network deductibles and co pays. **You are ultimately responsible for knowing your insurance benefits and the balance for services rendered.**

Claims are sent out to insurance companies periodically. Upon receipt of payment for services rendered, you will also receive statements from your insurance company, referred to as explanation of benefits (EOBs), which will inform you of any payments made. Since there are no guarantees of payment from the insurance company, you the patient are held liable for unpaid balances. On occasion, the insurance company will send a check for payment of services to the patient; should that occur, please endorse the check and bring payment directly to Source Chiropractic.

We encourage you to ask any questions you may have regarding our financial policy, so that you may have a clear understanding. Our goal is to concentrate on returning you to optimal health and to establish overall well-being.

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:

I authorize payment of medical benefits to Source Chiropractic for services rendered to me.

REIMBURSEMENT POLICY:

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

PATIENT ACKNOWLEDGEMENT:

I understand that the above information is not a guarantee of insurance benefits. Benefits will be determined by a number of factors by my insurance company, including but not limited to, eligibility at the time the services are rendered or medical necessity. I assume responsibility for all charges incurred on my account. I understand and agree that no doctor can or should guarantee results for any course of treatment and that correction cannot be guaranteed. I understand that this office does not know exactly what my insurance company will pay until payment is received. I understand that I am responsible for all payments after any deductible, co-payment and co-insurance is handled. I understand that my insurance is an agreement between me and my insurance company and all services rendered to me are my responsibility.

I understand that I have the option to decline and/or discontinue care at this office for any reason. In the event that care is discontinued, I will not be penalized in any fashion. Any unpaid balance associated with care which has actually been rendered shall continue to be payable. If there is credit remaining on my account, it will be refunded.

I have read, understand and agree to the above financial policy. I acknowledge that I am signing this notice voluntarily and that it is not being signed after services have been provided. I have had ample opportunity to ask questions about my financial obligations and other treatment options. I understand that by signing this form I am fully responsible for all non-covered services and any out of pocket costs associated with the covered services that I receive.

______________________	______________________	______________________
PATIENT SIGNATURE	**PATIENT PRINTED NAME**	**DATE**

Source Chiropractic • 1716 Memorial Dr • Clarksville, TN 37191 • Tel: (931) 591-3740

PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

Notice to Patient:
We are required to offer you a copy of our HIPAA notice which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

OPTIONAL:

1) May we confirm your appointments by email, text or phone? Yes No

2) May we leave a message on your answering device at home or cell phone? Yes No

3) May we discuss your condition with any members of your family? Yes No

If yes, provide names: ___________________________________

4) We utilize an open therapy room. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested. Are you comfortable being treated in an open room? Yes No

Patient Acknowledgement:
I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_________________________________ _________________________________
Patient Printed Name Patient Signature or legal representative

_________________________________ _________________________________
Date If legal representative, state relationship

FOR OFFICE USE ONLY:
We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:

___ the patient refused to sign
___ we were not able to communicate with the patient
___ due to an emergency situation it was not possible to obtain a signature
___ other (please provide details):

____
Name of patient

____
Name of staff member

____
Signature of staff member

____
Date

Informed Consent Document

PATIENT NAME: ____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audile “pop” or “click”, much as you experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal manipulative therapy
- Palpation
- Vital signs
- Postural analysis
- Range of motion testing
- EMS
- Decompression
- Other: ___________________
- orthopedic testing
- basic neurological testing
- muscle strength testing
- ultrasound
- hot/cold therapy
- radiographic studies
- laser therapy

***If you DO NOT consent any of the above analysis/examination/treatment, please inform the Doctor.**

The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some types of manipulation of the neck have been associated with injuries the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to the Doctor’s attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as t a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction furthering reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

The availability and nature of other treatment options.

Other treatment options for your condition may include

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Jeffrey Morrey or Dr. Cindy Morrey and have had my questions answered to my satisfaction. By signing below I state that I have weighted the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: ___________________________________ **Dated:** _________________________________

Patient Name: _____________________________ **Dr's Name:** _______________________________

Signature: _________________________________ **Signature:** _______________________________

CONSENT TO TREAT (MINOR)

I hereby request and authorize Dr. Jeffrey Morrey and/or Dr. Cindy Morrey to perform diagnostic test and render chiropractic adjustments and other treatment to my minor son/daughter: ________________________________. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature of Parent or Guardian (if a minor): ______________________________ **Date:** __________________