new health
CHIROPRACTIC

NEW PATIENT REGISTRATION FORM

Name _____ **Email** _____

Address _____**City** _____**State** _____**Zip Code** _____

Phone ( ) _____ **Birth Date** _____/_____ /_____

Employer _____ **Job Title** _____

Current Primary Doctor _____ **Date of last visit** _____

Referred by _____ **OR** ☐ **website** ☐ **event** ☐ **advertisement** ☐ **walk-in**

***** Preferred appointment notifications via ☐ email or ☐ text message (service carrier: _____)**

REASON FOR VISIT:

PLEASE ANSWER ALL OF THE QUESTIONS BELOW:

Do you experience any of the following?

☐Yes ☐No **Unexplained weakness of your arms or legs**
☐Yes ☐No **Unexplained numbness of your hands or feet**
☐Yes ☐No **Difficulty controlling your bowel or bladder**
☐Yes ☐No **Pain in your chest or arms**
☐Yes ☐No **Shortness of breath**
☐Yes ☐No **Unexplained weight loss**
☐Yes ☐No **Severe headache**

OFFICE USE ONLY
_____
_____
_____
_____

Allergies? ☐Yes ☐No; If yes, please list below

Medications? ☐Yes ☐No; If yes, please list below

Non-Smoker ☐ **Ex-Smoker** ☐ **Current Smoker** ☐ **-** How many packs per day?

Do you exercise routinely? ☐Yes ☐No**;** If yes, what type & how often**?**

Do you take nutritional supplements? ☐Yes ☐No; If yes, list below**:**

Have you received Chiropractic care in the past? ☐Yes ☐No; If yes, last visit?

Have you had any other treatments or therapies for your current condition? ☐Yes ☐No; If yes, provide detail**:**

Please initial: _____

Name:

History of Surgery □Yes □No If yes, provide details:
History of Injury □Yes □No If yes, provide details:

Please check appropriate box:

□ Arthritis	□ Pacemaker	□ Rheumatoid Arthritis
□ Asthma/COPD	□ Kidney Stones	□ Thyroid Disease
□ Blood Clots	□ Colitis	□ Migraine Headache
□ Cancer	□ Gastritis	□ Chronic Infection
□ Chronic Fatigue Syndrome	□ Ulcers	□ Fibromyalgia
□ Depression	□ GERD	□ PTSD
□ Diabetes	□ Gallstones	□ Dementia
□ Heart Disease	□ Osteoporosis	□ Stroke
□ High Cholesterol	□ Metabolic Syndrome	□ Menopause
□ High Blood Pressure	□ Adrenal Fatigue	□ Polycystic Ovarian Disease
□ Other:		

Family History: (Please list any known medical problems)

Father:
Mother:
Siblings:
Children:

Additional Information: Use this space to provide any additional information which may be important to your health.

The information provided above is accurate to the best of my knowledge. I hereby consent to an evaluation and understand that results are not guaranteed, no assurances have been made, and as with any health care practice, there are certain risks associated with chiropractic in addition to the other modalities utilized in this office. I will be given the opportunity to ask questions about the services provided and by signing below, I consent, but at any time have the right to decline, the recommendations and treatment provided by Dr. Morris. Also, I understand that any clinical nutrition protocols provided by Dr. Morris are not implemented to diagnose and/or treat any medical condition(s). I have read, or have had read to me, the above consent.

Patient Signature: **Date:**

Consent for evaluation and treatment a minor:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic evaluation and treatment.

Signature of Parent or Guardian **Date**

Signature of Reviewing Doctor **Date**

"HIPAA" Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* or have the right to view this policy, which contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature of Patient **Date**

Signature of Parent or Guardian **Date** **Relationship to Patient**

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We have made every effort to obtain written **acknowledgement** of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details):*

_____

_____ _____

Doctor Signature Date