

UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Today's Date (MM/DD/YYYY) _____

Gender
 Male Female

Your Last Name _____

Your Social Security Number _____

Your First Name _____

Your Middle Name (or Initial) _____

Birth Date (MM/DD/YYYY) _____

Marital Status
 Single Married Divorced

 Widowed Separated

Address _____

City _____

State/Province _____

ZIP/Postal Code _____

Home Phone _____

Spouse's Name _____

Email Address _____

Cell Phone _____

Child's Name and Age _____

Emergency Contact _____

Phone _____

Child's Name and Age _____

Your Occupation _____

Child's Name and Age _____

Your Employer _____

May we contact you at work?
 Yes No

Preferred method of contact?
 Home Phone Cell Phone

 Work Phone Email

Address _____

City _____

State/Province _____

ZIP/Postal Code _____

Work Phone _____

Insurance Carrier _____

Policy Number _____

Primary Care Provider's Name _____

Insured's Last Name _____

Birth Date (MM/DD/YYYY) _____

Who carries this policy?
 Self Spouse Parent

First Name _____

Middle Name (or Initial) _____

Insured's Employer _____

Address _____

City _____

State/Province _____

ZIP/Postal Code _____

Employer's Phone _____

I certify that any changes to my personal information have been updated above for your records.

Signature _____

UPDATED CONTACT INFORMATION

UPDATED PATIENT HISTORY

Today's Date (MM/DD/YYYY) _____

Your Last Name _____

Your First Name _____

Your Middle Name (or Initial) _____

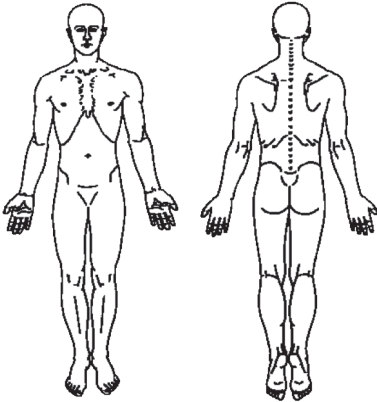
I have new contact information

Please select one:

- Progress evaluation** – I've been under active care and this is a periodic reevaluation.
- New condition** – I've been under care and a new or returning condition has emerged.
- Maintenance patient** – I'm under maintenance care with a new or returning health issue.
- Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

Current symptoms: _____

1. Location (Where does it hurt?)
 Circle the area (s) on the illustration.



2. Quality of symptoms (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other _____

3. Intensity (How extreme are your current symptoms?)



4. Duration and Timing (When did it start and how often do you feel it?)

- Constant Come and goes.
- When did it start and how often? _____

5. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

6. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____
 What tends to lessen the problem? _____

7. Prior interventions (What have you done to relieve the symptoms?)

- | | | |
|---|------------------------------------|----------------------------|
| <input type="radio"/> Prescription medication | <input type="radio"/> Surgery | <input type="radio"/> Ice |
| <input type="radio"/> Over-the-counter drugs | <input type="radio"/> Acupuncture | <input type="radio"/> Heat |
| <input type="radio"/> Homeopathic remedies | <input type="radio"/> Chiropractic | Other _____ |
| <input type="radio"/> Physical therapy | <input type="radio"/> Massage | _____ |

8. What else should Dr. Morris know about your current condition? _____

9. Review of systems (Identify any changes since your most recent evaluation with us):

	Worse	No Change	Improved
a. Musculoskeletal System – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Neurological System – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Cardiovascular System – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Respiratory System – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Digestive System – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Sensory System – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Skin System – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Endocrine System – Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Genitourinary System – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Constitutional System – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Illnesses, operations, injuries or treatments since your most recent evaluation with us: _____

This updated patient history is for:

- Current Patient Periodic Re-evaluation
- Current Patient Additional Complaint/Exacerbation
- Maintenance Patient (circle one) Exacerbation Re-Occurrence New Episode
- Inactive Patient (circle one) Exacerbation Re-Occurrence New Episode

Consultation Notes

Doctor's Initials _____

UPDATED PATIENT HISTORY

11. Social History (Tell Dr. Morris about your health habits and stress levels.)

Alcohol use Daily Weekly How much? _____
 Coffee use Daily Weekly How much? _____
 Tobacco use Daily Weekly How much? _____
 Exercising Daily Weekly How much? _____
 Pain relievers Daily Weekly How much? _____
 Soft drinks Daily Weekly How much? _____
 Water intake Daily Weekly How much? _____
 Hobbies: _____

Prayer or meditation? Yes No
 Job pressure/stress? Yes No
 Financial peace? Yes No
 Vaccinated? Yes No
 Mercury fillings? Yes No
 Recreational drugs? Yes No

Patient name

12. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

13. Is there anything else Dr. Morris should know about your current condition, your progress or ways your current condition is affecting your life?

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

If the patient is a minor child, print child's full name: _____

Consultation Notes

Doctor's Initials

**Morris Chiropractic
 Dr. Barry E. Morris**

 Signature

 Date (MM/DD/YYYY)