Morin Chiropractic P.A.

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To be performed by clinic staff: **Height:_____' _____"** **Weight: _______**lbs **Blood Pressure: ______/_______**

Patient Title: ❑Mr. ❑Mrs. ❑Ms. ❑Miss ❑Dr. ❑Prof. ❑Rev. **Gender:** ❑Male ❑Female ❑Unspecified

First Name:________________________ **Middle Initial:**______ **Last Name:**_________________________

Nickname:__________________________ **Birth Date:**_____/_____/_______ **SSN#**_______-_____-_______

Street Address:____

City:___________________________________ **State:**_______________________ **Zip Code:**_______________

Email Address:____❑Home or ❑Work Email

By providing my email address, I authorize my doctor to contact me via the email address provided.

Home: (_____) _______-________**Work:** (_____) _______-_______ext._______ **Cell:** (_____) _______-________

How do you prefer to be contacted? ❑Home Phone ❑Work Phone ❑Cell Phone ❑Other:__________________

Employment Status: ❑Employed ❑Full Time Student ❑Part Time Student ❑Retired ❑Self Employed ❑Other

Marital Status: ❑Single ❑Married ❑Other **Do you have any children?** ❑Yes ❑No

Race: ❑White ❑Black/African ❑American ❑Hispanic ❑American Indian/Alaskan Native ❑Asian ❑Asian Indian ❑Chinese ❑Filipino ❑Japanese ❑Korean ❑Vietnamese ❑Native Hawaiian or other Pacific Island ❑Guamanian or Chamorro ❑Samoen ❑Other ❑I choose not to specify

Multi-Racial: ❑Yes ❑No ❑ Unknown **Ethnicity**: ❑Hispanic or Latino ❑Not Hispanic or Latino ❑ Unspecified

Preferred Language: ❑English ❑Spanish ❑American Sign Language ❑Chinese ❑French ❑German ❑Polish ❑Tagalog ❑Vietnamese ❑Italian ❑Korean ❑Russian ❑Arabic ❑Portuguese ❑Japanese ❑French ❑Creole ❑Greek ❑Hindi ❑Persian ❑Urdu ❑Gujarati ❑Armenian ❑I choose not to specify

Is this related to a work injury? ❑Yes ❑No **If Yes, have you notified your employer?** ❑Yes ❑No
Is this related to an automobile accident? ❑Yes ❑No **If Yes, have you retained an attorney?** ❑Yes ❑No

Who referred you to our office? ____

Verification Question: (choose only one question)
❑What is the name of your favorite pet? ❑What city were you born in? ❑What high school did you attend? ❑What is your favorite movie? ❑What is your mother's maiden name? ❑What street did you grow up on? ❑What was the make of your first car? ❑When is your anniversary? ❑What is your favorite color?

Verification Answer to the Chosen question: ____

Answers must be at least 6 characters.

Patient Signature:____ **Date:**______________________

(Guardian if Minor)

<u>Current Complaints</u>

1. Area of Pain:____
The pain is: ❑ Constant ❑ Intermittent; usually lasts for ________minute(s), ________hour(s), _______day(s), ________week(s).
Please choose the number which best describes your pain in each of the questions below:
What level is your pain **RIGHT NOW?**

No	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	Unbearable
Pain=	0	1	2	3	4	5	6	7	8	9	10	=Pain

This pain is aggravated by:____

This pain is relieved by:____

2. Area of Pain:____
The pain is: ❑ Constant ❑ Intermittent; usually lasts for ________minute(s), ________hour(s), _______day(s), ________week(s).
Please choose the number which best describes your pain in each of the questions below:
What level is your pain **RIGHT NOW?**

No	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	Unbearable
Pain=	0	1	2	3	4	5	6	7	8	9	10	=Pain

This pain is aggravated by:____

This pain is relieved by:____

3. Area of Pain:____
The pain is: ❑ Constant ❑ Intermittent; usually lasts for ________minute(s), ________hour(s), _______day(s), ________week(s).
Please choose the number which best describes your pain in each of the questions below:
What level is your pain **RIGHT NOW?**

No	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	Unbearable
Pain=	0	1	2	3	4	5	6	7	8	9	10	=Pain

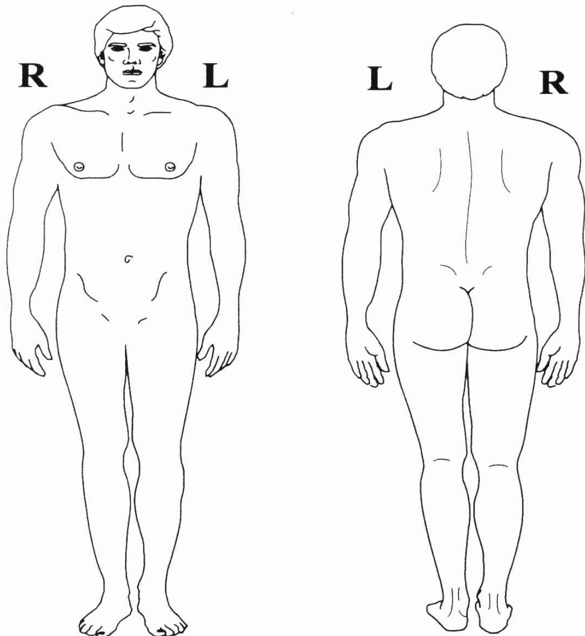
This pain is aggravated by:____

This pain is relieved by:____

4. Other:____

In general my symptoms are better in: ❑ morning ❑ mid day ❑ evening
In general my symptoms are worse in: ❑ morning ❑ mid day ❑ evening
❑ symptoms do not change with the time of day.
Do you have night pain unrelated to movement? ❑ Yes ❑ No
Do you have constant pain unrelated to movement? ❑ Yes ❑ No
Are your symptoms/condition: ❑ Improving ❑ Unchanged ❑ Getting worse

Use the symbols in the box to the right to mark the location and the type of pain or sensations you are feeling.



>>>	Aching Pain
XXX	Burning Pain
= = =	Numbness
0000	Pins & Needles
/ / / / /	Stabbing Pain

Face or Head Pain:

❑Right side ❑Left side ❑Both

The pain/complaint began on or about:____

How long have you been having pain? ❑ 1 week or less ❑ 1 to 6 weeks ❑ 6 weeks to 3 months ❑ 3 months to 1 year ❑ Over 1 year

Do you have a primary care / family physician? ❑ Yes ❑ No

If Yes, Name:______________________________ Address:____________________________________

Have you seen specialist(s) for this condition? ❑ Yes ❑ No

If Yes, Name:______________________________ Address:____________________________________

If Yes, Name:______________________________ Address:____________________________________

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

Medical History

Please list any history hospitalization or surgeries.

❑ Hospitalization ❑ Surgery Date:______________ Reason:________________________________

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Has any doctor diagnosed you with Hypertension presently?

❑ Yes ❑ No ❑ Not Sure If yes, what kind?____

Has any doctor diagnosed you with Diabetes presently?

❑ Yes ❑ No If yes, what kind? ❑ Type I ❑ Type II

Was your blood lab-work test for hemoglobin A1C >9.0%? ❑ Yes ❑ No ❑ Not Sure

Has any doctor diagnosed you with any type of significant health syndrome presently?

❑ Yes ❑ No ❑ Not Sure If yes, what kind?____

Medical History Continued

Do you **NOW** have any of the following conditions? **(Mark if YES)**

- ❑ Congestive heart failure
- ❑ Chronic lung disease (including bronchitis or emphysema)
- ❑ Blindness or trouble seeing, even when wearing glasses
- ❑ Deafness or trouble hearing
- ❑ Kidney disease
- ❑ Depression
- ❑ Asthma
- ❑ Ulcer or gastrointestinal bleeding (not hemorrhoids)
- ❑ Cancer If yes, What kind?_________________________
- ❑ Sciatica or chronic back problems
- ❑ Pacemaker
- ❑ Angina
- ❑ Heart attack/myocardial infarction
- ❑ Stroke
- ❑ Hemorrhoids
- ❑ Currently Pregnant
- ❑ Allergies
- ❑ Arthritis or rheumatism
- ❑ Other____

Please list current medications including dosage, if known. Prescribed or over the counter.

❑ I currently take no medications

Medication Name	Dosage	Frequency

Please list any known allergies that you have to any medications.

❑ I have no known allergies to medication.

____

____

____

____

What is the name of the Pharmacy you use? ___________________________________

Where is the Pharmacy you use located? ______________________________________

Family History

Check if any of your family members has any of the following:

Cancer	❑ No	❑ Yes	Relation:	❑ mother	❑ father	❑ brother	❑ sister
Tuberculosis	❑ No	❑ Yes	Relation:	❑ mother	❑ father	❑ brother	❑ sister
Diabetes	❑ No	❑ Yes	Relation:	❑ mother	❑ father	❑ brother	❑ sister
Heart Trouble	❑ No	❑ Yes	Relation:	❑ mother	❑ father	❑ brother	❑ sister
High Blood Pressure	❑ No	❑ Yes	Relation:	❑ mother	❑ father	❑ brother	❑ sister
Stroke	❑ No	❑ Yes	Relation:	❑ mother	❑ father	❑ brother	❑ sister
Epilepsy	❑ No	❑ Yes	Relation:	❑ mother	❑ father	❑ brother	❑ sister
Stomach Disorders	❑ No	❑ Yes	Relation:	❑ mother	❑ father	❑ brother	❑ sister
Asthma	❑ No	❑ Yes	Relation:	❑ mother	❑ father	❑ brother	❑ sister
Allergy / Hay Fever	❑ No	❑ Yes	Relation:	❑ mother	❑ father	❑ brother	❑ sister
Headaches	❑ No	❑ Yes	Relation:	❑ mother	❑ father	❑ brother	❑ sister
Chemical Dependency	❑ No	❑ Yes	Relation:	❑ mother	❑ father	❑ brother	❑ sister
Arthritis / Gout	❑ No	❑ Yes	Relation:	❑ mother	❑ father	❑ brother	❑ sister
Back Problems	❑ No	❑ Yes	Relation:	❑ mother	❑ father	❑ brother	❑ sister

If any of your family members are deceased, please list the cause of death and their age in the following space:____

____

Social History

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ never been a smoker

If yes, how often do you smoke? ❑ Current everyday smoker ❑ Current someday smoker

Packs smoked per day? ______________________ Years smoked?______________________

If you are a former smoker, How many years since you quit? ______________________

What is your level of interest in quitting smoking? (Circle one) **0 1 2 3 4 5 6 7 8 9 10 N/A**

Do you consume alcohol? ❑ No ❑ Yes If Yes, how many drinks in an average day? ____________

Do you consume coffee? ❑ No ❑ Yes If Yes, how many drinks in an average day? ____________

Do you consume soda pop? ❑ No ❑ Yes If Yes, how many drinks in an average day? ____________

Do you use any recreational drugs? ❑ No ❑ Yes If Yes, how often? ______________________

Do you use pain relievers? ❑ No ❑ Yes If Yes, how many do you take in an average day? __________

How would you rank your healthy eating habits. (Circle one) **0 1 2 3 4 5 6 7 8 9 10 N/A**

Physical Stress Level? (Circle one) **0 1 2 3 4 5 6 7 8 9 10 N/A**

Emotional Stress Level? (Circle one) **0 1 2 3 4 5 6 7 8 9 10 N/A**

What are your major stressors? ____

Do you exercise regularly? ❑ No ❑ Yes If Yes, How frequently? ______________________

Please describe the type of exercise:____

____

List any hobbies or recreational sports you enjoy:______________________________________

____

Current Difficulty Level? (Circle one) **0 1 2 3 4 5 6 7 8 9 10 N/A**

Prior Difficulty Level? (Circle one) **0 1 2 3 4 5 6 7 8 9 10 N/A**

What are your other health goals? ____

Work History / Job Demands

What is your job description? ____

Employer:___________________________ Telephone #:(_______) ________-__________

Address:____

Are you currently able to work? ❑ Yes ❑ No

If No, list date(s) out of work:____

How many hours do you normally work in a week?____

What is the physical stress level of your job? (Circle one) **Low** **Medium** **High**

Please list your work activities.

____

____

____

____

____

____

____

Fill out this section if your injury is related to an Automobile Accident.

Date of accident:_______________________ Hour:_________________ ❑a.m. ❑p.m.

Were you the: ❑ driver ❑ passenger ❑ front seat ❑ back seat ❑ pedestrian

Were the roads: ❑ dry ❑ wet ❑ snowy, icy Were you wearing a seat belt? ❑ Yes ❑ No

Were you struck from: ❑ behind ❑ driver's side ❑ passenger's side ❑ head on ❑ both front and rear ❑ both front and side ❑ moving forward

At the time of impact was your vehicle: ❑ stopped ❑ moving forward

Was your air bag deployed? ❑ Yes ❑ No

Do you recall any part of your head or body striking any part of the interior of the car? ❑ Yes ❑ No

If Yes, please describe:____

____

Type of vehicle you were in:_________________ Type of vehicle that struck you:__________________

Head / body position at time of impact:

❑ head turned to the left / right ❑ head looking back ❑ head straight forward

❑ body straight in sitting position ❑ body rotated to left / right ❑ other:______________

Did you feel pain: ❑ immediately ❑ gradually ❑ next day ❑ other:_______________________

Were you knocked unconscious? ❑ Yes ❑ No If Yes, for about how long __________❑second(s) ❑minute(s)

Did you receive first aid at the scene of the accident? ❑ Yes ❑ No

Did you go to the hospital by: ❑ ambulance ❑ a friend ❑ drove yourself

Name of hospital:____

Did the hospital take x-rays? ❑ Yes ❑ No If Yes, what area(s) of the body:______________________

What treatment was given:____