

Patient Health History

MORLOCK CHIROPRACTIC CENTER, LTD

Today's Date / Patient Account # _____

Patient Title: (check one) Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name _____ Nick Name _____

Last Name _____ Middle Name _____ Suffix _____

Address _____

City _____ State _____ Zip Code _____

Primary Phone _____ Work Phone _____

Mobile Phone _____

Home email _____ Work Email _____

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

Which email address would you like us to use to communicate with you? (check one) Home Work

Contact Method (check one)

Primary Phone Secondary Phone Mobile Phone Home Email Work Email

Date of Birth / Age _____ Gender (check one) Male Female Unspecified

Marital Status (check one) Single Married Other SS# _____

Emergency Contact Name & Phone _____

Employment Status (check one)

Employed FT Student PT Student Other Retired Self Employed

Occupation _____

Referred by _____

Race (check one)

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

Multi-Racial (check one) Yes No Unknown

Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino I choose not to specify

Preferred Language (check one)

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

Verification Question (choose only one question by circling the question, then give the answer to that question)

- What is the name of your favorite pet? In what city were you born? What high school did you attend?
- What is your favorite movie? What is your mother's maiden name? On what street did you grow up?
- What was the make of your first car? When is your anniversary? What is your favorite color?

Verification Answer to the Chosen question: _____

Answer needs to have 7 or more characters

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

If yes, how often do you smoke: Current every day smoker Current sometimes smoker

If yes, what is your level of interest in quitting smoking?

- 0 1 2 3 4 5 6 7 8 9 10
- No interest* *Very Interested*

Current medications, including frequency and dosage if known. If there are no current medications, check here:

	Dosage		Dosage
1) _____		5) _____	
2) _____		6) _____	
3) _____		7) _____	
4) _____		8) _____	

List any known allergies you have had to any medications.

If no allergies are known, check here:

- 1) _____ 3) _____
- 2) _____ 4) _____

Primary reason for consulting our office: _____

Any other associated complaints: _____

How long has this been going on? Days _____ Weeks _____ Months _____ Years _____

Any related incidents in your life? _____

Seen other chiropractors N Y **Who** _____

Name of MD _____

Others seen for this condition _____

Has any doctor diagnosed you with Hypertension (High Blood Pressure) presently? Yes No If yes, describe:

Has any doctor diagnosed you with Diabetes presently? Yes No If yes, what kind? Type I Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes No Not Sure

If yes, other comments regarding Diabetes: _____

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

To be performed by clinic staff:

Height: _____ inches Weight: _____ pounds BP: _____/_____ Pulse: _____

AGREEMENTS

Informed consent to chiropractic care.

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures and if necessary diagnostic x-rays on me by the Doctor of Chiropractic (Gregg P. Morlock, DC) and/or anyone authorized by the same doctor. I further understand and am informed that, as in all health care, there are some slight risks to treatment and do not expect the doctor to be able to anticipate or explain all risks and combinations; and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. I have read this consent and intend this consent form to cover the entire course of my care for this condition and any care in the future.

Signature _____ Print Name _____

Witness _____ Date _____