Confidential Patient Information

Name: ______________________________ Date of Birth: ________________ Date: _____________

Current Address: ________________________________ Home Phone: _________________________

City, State, Zip: ________________________________ Cell Phone: __________________________

E-mail Address: _________________________________ Would you like to be added to our mailing list? Y N

Emergency Contact Name & Phone Number: ____

List any physical complaints you'd like to discuss with the doctor. __________________________

____

Who may we thank for referring you? ____

My previous treatments and tests included (circle all that apply):

- Acupressure
- Acupuncture
- Antibiotics
- Chiropractic Adjustments
- Cold/heat packs
- Other:
- Hydro massage Therapy
- Infrared Therapy
- Massage Therapy
- Muscle Stimulation
- Ultrasound Therapy

____

____

My past health conditions include:

- ____

____

My family history includes:

- ____

____

My social habits include:

- Alcohol
  - None
  - Occasional
  - Social
  - 1-2 drinks/day
  - 3+ drinks/day
- Smoking
  - Never a smoker
  - Ex-Smoker
  - Currently smoke (How many packs per day?____)
- Recreational Drugs
  - No
  - Yes (What and how long? ____________________)

Please list all medications, both prescribed and over-the-counter, with the dosage and how often the medication is used:

____

____

Please list any vitamins (including dosage) that you are currently taking: ______________________

____

Allergies: ____

____

Surgeries (if so, when): ____

____

Chemical Balance Questionnaire

Speed of healing is determined by **chemical balance** in the body. Chemical balance is determined, in large, by **what you eat.** Please indicate the amounts and frequencies you partake in the following **(BE HONEST!):**

	Per Day	Per Week
1. Coffee (caff/decaf)	_____ cups	_____ cups
2. Tea (herbal/regular)	_____ cups	_____ cups
3. Sugar, sweets, desserts, candy	_____ times	_____ times
4. Salt, salty snacks, chips, etc.	_____ servings	_____ servings
5. Do you add salt to food at meal time?	_____ yes______no	_____ occasionally
6. Red meat (beef, pork, bacon, ham, etc.)	_____ servings	_____ servings
7. Chicken/fish	_____ servings	_____ servings
8. Milk	_____ glasses/times	_____ glasses/times
Other Dairy (cheese, ice cream, etc.)	_____ oz	_____ oz
9. Water	_____ glasses	_____ glasses
10. Fresh fruits	_____ servings	_____ servings
11. Fresh vegetables (non-canned)	_____ servings	_____ servings
12. Pasta, breads (made with white flour)	_____ servings	_____ servings
13. Whole grain foods	_____ servings	_____ servings
14. Artificially sweetened products (Splenda, Sweet-N-Low, Equal, Aspartame, etc.)	_____ servings	_____ servings
15. Fast Food (McDonalds, Hardees, etc.)	_____ times	_____ times
16. Fats (nuts, avocado, coconut, oils, etc.)	_____ times	_____ times
17. Processed Foods (cereals, boxed or frozen meals)	_____ times	_____ times
18. Alcoholic beverages	_____ servings	_____ servings
19. Soft drinks (regular/caffeine-free)	_____ oz	_____ oz
Diet Soda	_____ oz	_____ oz

Cravings (circle ones that apply): salt sugar chocolate bitter carbs/starches ice

What is a typical breakfast for you?

____

What is a typical lunch for you?

____

What is a typical evening meal for you?

____

REVIEW OF SYSTEMS (please check all that apply) Patient Name: ____________________

Constitutional
- ☐ Chills
- ☐ Drowsiness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Eyes
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Field Cuts
- ☐ Glaucoma
- ☐ Sensitivity to Light
- ☐ Tearing
- ☐ Wears Glasses

Cardiovascular
- ☐ Angina
- ☐ Chest Pain
- ☐ Claudication
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Swelling of Legs
- ☐ Varicose Veins

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Dry Cough
- ☐ Productive Cough
- ☐ Coughing up Blood
- ☐ Difficulty Breathing
- ☐ Difficulty Sleeping
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Wheezing

Musculoskeletal
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Decreased Motion
- ☐ Gout
- ☐ Injuries
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Locking Joints
- ☐ Back Pain
- ☐ Muscle Cramps
- ☐ Muscle Pain
- ☐ Muscle Twitching
- ☐ Muscle Weakness
- ☐ Swelling

Integumentary
- ☐ Breast Pain
- ☐ Nail Texture Change
- ☐ Skin Color Change
- ☐ Eczema
- ☐ Hair Growth
- ☐ Hair Loss
- ☐ History of Skin Disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Skin Lesions

ENMT
- ☐ Bad Breath
- ☐ Dentures
- ☐ Deviated Septum
- ☐ Difficulty Swallowing
- ☐ Discharge
- ☐ Dry Mouth
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Head Injury
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Loss of Taste
- ☐ Nasal Congestion
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Infections
- ☐ Runny Nose
- ☐ Snoring
- ☐ Sore Throat
- ☐ Ringing In Ears
- ☐ TMJ Problems
- ☐ Ulcers

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Belching
- ☐ Black, Tarry Stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Abnormal Stool Caliber
- ☐ Abnormal Stool Color
- ☐ Abnormal Stool Consistency
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Birth Control Therapy
- ☐ Burning Urination
- ☐ Cramps
- ☐ Erectile Dysfunction
- ☐ Frequent Urination
- ☐ Hesitancy / Dribbling
- ☐ Hormone Therapy
- ☐ Irregular Menstruation
- ☐ Lack of Bladder Control
- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge

Neurological
- ☐ Change in Concentration
- ☐ Change in Memory
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of Consciousness
- ☐ Loss of Memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep Disturbance
- ☐ Slurred Speech
- ☐ Stress
- ☐ Strokes
- ☐ Tremors

Psychiatric
- ☐ Agitation
- ☐ Anxiety
- ☐ Appetite Changes
- ☐ Behavioral Changes
- ☐ Bipolar Disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Homicidal Indication
- ☐ Insomnia
- ☐ Location Disorientation
- ☐ Memory Loss

Endocrine
- ☐ Cold Intolerance
- ☐ Diabetes
- ☐ Excessive Appetite
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Goiter
- ☐ Hair Loss
- ☐ Heat Intolerance
- ☐ Unusual Hair Growth
- ☐ Voice Changes

Hematologic / Lymphatic
- ☐ Anemia
- ☐ Bleeding
- ☐ Blood Clotting
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Lymph Node Swelling

Allergic / Immunologic
- ☐ History of Anaphylaxis
- ☐ Itchy Eyes
- ☐ Sneezing
- ☐ Specific Food Intolerance

FEMALES ONLY:
When was your last period?
Are you pregnant? Yes No

COMMUNICATIONS POLICY:

Please indicate below which, if any of the following methods we may use to contact you regarding your care, treatment, classes, and events.

Please check **only one** of the following reminder types:

- ☐ No thank you, opt out
- ☐ Text Message (standard messaging rates apply)
- ☐ E-mail
- ☐ Automated Voicemail **Home**
- ☐ Automated Voicemail **Cell**

FINANCIAL AGREEMENT:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree to allow this chiropractic office to use the Patient Health Information (PHI) for the purpose of treatment, payment, healthcare, operations, and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that I will be financially responsible for all collection/legal fees incurred for the collection of any unpaid balance. I understand that the office requires 24-hour notice of cancellation of my appointment.

Patient Signature ______________________________ **Date** ____________________

If the patient is a minor or under a guardianship order as defined by State Law:

By:____

Signature of Parent/Guardian (circle one)

Scott A. Cooper Inc. dba Morter HealthCenter
10439 Commerce Dr. Suite 140
Carmel, Indiana 46032
PH: 317-872-9300

Consent to use PHI

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Scott A. Cooper Inc. dba Morter HealthCenter or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

_______Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

____ ____________
Patient or Legally Authorized Individual Signature Date

____ ____________
Print Patient's Full Name Time

____ ____________
Witness Signature Date