



Morrow Chiropractic New Patient Paperwork

Thank you for choosing Morrow Chiropractic. Please complete the following forms to help us provide the best possible care.

Patient Information

Full Name: _____ Date of Birth: _____ Gender: M / F

Address: _____ Phone Number: _____

Email: _____

Emergency Contact Name & Phone: _____

Relationship to Patient: _____

Reason for Visit

Symptom Onset

When did your symptoms begin? _____

Cause (if known): Gradual onset Sudden onset Injury/Accident

If injury/accident, please describe: _____

Describe your main complaint:

Pain Level (0-10)

0 = No pain, 10 = Worst pain imaginable

Current pain level: 0 1 2 3 4 5 6 7 8 9 10

Worst pain in the last 72 hours: 0 1 2 3 4 5 6 7 8 9 10

Best pain in the last 72 hours: 0 1 2 3 4 5 6 7 8 9 10

Have you received previous treatment for this condition?

Medical History

Current Medications:

Allergies:



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Lifestyle Information

Occupation: _____ Work Duties: _____
Exercise Frequency: _____ Smoking: Yes / No Alcohol Use: Yes / No

History of Motor Vehicle Accidents, Traumas, or Surgeries

Have you been involved in any motor vehicle accidents?

List any significant traumas, injuries, or surgeries (with dates):



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Financial Responsibility Agreement

No Refund Policy

All goods and services provided at our office are **NON-REFUNDABLE**. This includes individual services, packages, and memberships. No returns or exchanges will be accepted.

Packages

- Packages are NON-REFUNDABLE once purchased.
- If you elect to make payments on your package, your payment schedule will begin on the date of the first payment and continue on the same calendar day of each subsequent month until the package is fully paid.
 - Example: if your first payment is on the 1st of the month, the next two payments will be due on the 1st of the next two months.

I understand that I am financially responsible for all charges, whether or not covered by insurance. I agree to pay copayments, deductibles, and any non-covered services.

Patient Signature: _____ **Date:** _____

Person Responsible for Payment

Name of Responsible Party: _____

Relationship to Patient (If applicable): _____

Payment Policy: Payment is expected at the time of each visit unless other arrangements have been made in advance.

Signature of Responsible Party: _____ **Date:** _____

Office Policies

Maintenance Memberships

- Maintenance memberships are valid for **six (6) calendar months** from the start date.
- Any changes or adjustments to your membership must be discussed and approved by the doctor prior to implementation.

No-Show/No-Call Policy

- Your first no-show/no-call will result in the loss of **one adjustment** from your package or maintenance membership.
- Any additional no-shows or no-calls will result in your card on file being charged **\$40 per missed appointment**.

Patient Initials: _____



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Location of Symptoms

(Check all that apply)

- Neck
- Mid Back
- Low Back
- Shoulders
- Elbows
- Wrists/Hands
- Hips
- Knees
- Ankles/Feet
- Headaches
- Other: _____

Frequency of Symptoms

- Constant (75-100% of the time)
- Frequent (50-74% of the time)
- Occasional (25-49% of the time)
- Intermittent (0-24% of the time)

Activities That Aggravate Symptoms

(Check all that apply)

- Bending
- Lifting
- Sitting
- Standing
- Walking
- Exercise
- Driving
- Sleeping
- Working
- Other: _____

Activities That Relieve Symptoms

(Check all that apply)

- Rest
- Ice
- Heat
- Stretching
- Medication
- Massage
- Chiropractic care
- Other: _____

Impact on Daily Activities

(Check all that apply)

- Work limitations
- Difficulty sleeping
- Reduced exercise ability
- Difficulty with daily tasks
- Affects mood/stress
- Other: _____

Previous Care for This Condition

(Check all that apply)

- Chiropractic
- Physical Therapy
- Massage Therapy
- Other: _____



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Patient Goals for Care

What would you like to achieve through chiropractic care?

Pain reduction goals: _____

Mobility/function goals: _____

Activity or lifestyle goals: _____

Other goals: _____

Patient Signature: _____ **Date:** _____

Additional Notes



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Chiropractic Informed Consent Form

Purpose of Chiropractic Care

The purpose of chiropractic treatment is to reduce pain, improve function, and support the body's natural ability to heal. Chiropractic care may include spinal adjustments, physical therapy modalities, soft tissue techniques, exercises, and lifestyle recommendations.

Nature of Chiropractic Treatment

Chiropractic adjustments involve the application of a controlled force to joints of the spine and/or extremities. Other supportive therapies may include stretching, traction, muscle stimulation, ultrasound, manual therapy, and rehabilitative exercises.

Potential Risks

While chiropractic care is generally safe, as with any healthcare procedure, there are potential risks. These may include, but are not limited to temporary soreness or discomfort, muscle or ligament strain, aggravation of a pre-existing condition, dizziness or lightheadedness, rib fracture (rare), disc injury or nerve irritation (rare), stroke or stroke-like symptoms (extremely rare).

Potential Benefits

Benefits of chiropractic adjustments include reduction of pain, improved mobility and alignment, increased function and performance, support for healing and recovery, and enhanced overall well-being.

No Guarantee

I understand that each patient responds differently to treatment and that results are not guaranteed.

Right to Ask Questions

I understand that I may ask questions at any time regarding my treatment, condition, or any risks involved.

Right to Refuse or Discontinue Care

I understand that I may refuse treatment at any time and may discontinue care whenever I choose.

Teaching Training Acknowledgment

Our office frequently hosts chiropractic students who are learning or training with our doctors.

I acknowledge the presence of students and understand that educational videos may be recorded. If I do **NOT** wish to appear on camera, I will inform the staff.

Patient Initials: _____

Consent for Treatment

I hereby request and consent to chiropractic treatment and any related procedures recommended by the Doctor of Chiropractic and/or clinical staff.

SIGNATURES

Patient Name: _____

Signature: _____ Date: _____

Parent/Guardian (if patient is a minor): Name: _____

Signature: _____ Date: _____

Witness/Doctor:

Name: _____

Signature: _____ Date: _____