Dr. Brett A. Morgan
Chiropractic Physician
Applied Kinesiologist

PATIENT INFORMATION

TRUE HEALTH
135 7th Avenue SW
So. Charleston, WV 25303

PERSONAL INFORMATION

Last Name_____ First_____ Nickname_____ Middlle Initial____
Prefix_____ Generation_____ Sex_____ DOB_____ SSN_____
Marital Status_____ Height_____ Weight_____
Address_____ City_____ State_____ Zip_____
Phone (Home)_____ (Work)_____ (Cell)_____
Email_____ Occupation_____ Employer_____
Who referred you to our office/How did you hear about us? (please be specific)_____
Emergency Contact_____ Relationship_____ Phone_____

Insurance Information & Privacy Practices Acknowledgement

Primary Insurance Company_____
Insured Name_____ Relationship_____ Date of Birth_____
Identification #_____ Group #_____

Secondary Insurance Company_____
Insured Name_____ Relationship_____ Date of Birth_____
Identification #_____ Group #_____

Please provide us with any additional insurance information at your first visit or as it may change.

I authorize release of all information necessary to process my insurance claims. I assign and request payment directly to my physician. I understand all charges, deductibles, co-payments and/or co-insurance are the responsibility of the patient and verification of benefits does not guarantee payment. I agree to pay for all charges deemed as patient responsibility and any charges for non-covered services as required by law.

As part of your health care, it is necessary to create, maintain and (in certain situations) share medical information concerning your health history and current health care services to carry out treatment, payment and health care options. Our **Notice of Privacy Practices** describes how we may use and disclose your protected health information. You have the right to review our notice before signing this consent. The terms of our notice may change. A current copy of the notice will be available in our facility and you may request one at any time.

By signing this form, you consent to our use and disclosure of your protected health information and acknowledge that you have reviewed our **Notice of Privacy Practices**. You have the right to revoke this consent, in writing, except where we have already used or disclosed your information in reliance on your prior consent. **By signing this form, I also agree that I have received, read, and understood a copy of True Health's Office Policies and Procedures. I am aware that this form will be retained in my medical record.**

_____ _____
Print Patient's Full Legal Name **Date**

_____ _____
Patient Signature or Legally Authorized Individual/Guardian **Date**

_____ _____
True Health Employee Signature **Date**

First Visit Date_____ **PIN**_____ **(For office use only)**

Phone: (304)-768-6106 Fax: (304)-746-0608 Email: truehealthwv@gmail.com Web: www.truehealthwv.com

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PRIMARY CONCERN

What is the reason for today's visit? _____
_____

Date of first occurrence_____ Date of most recent occurrence_____

Is your condition the result of an accident? (please explain…Car? Work?)_____

Have you had this or similar symptoms in the past? _____

What makes you feel better? _____ Worse? _____

How would you describe the pain? (burning, sharp, stabbing, dull, aching…) _____

How would you rate your pain on a scale of 1-10? (1 is almost no pain, 10 is worst ever) _____

Is the condition getting worse? _____ Is it worse at a certain time of day? _____

Is the condition constant? _____ Does it come & go? (explain) _____

Is this condition interfering with Work/School?_____ Sleep? _____ Activities?_____

Please list your goals for treatment (immediate & future): _____
_____

Are you also concerned with optimizing your overall health and well-being? _____

HEALTH HISTORY

List other current health issues & problems: _____
_____

List other practitioners seen, treatments, self-care activities & results: _____
_____

List any illness you may have had if not previously mentioned: _____

List all surgeries with dates & results: _____

Have you ever been in an accident or seriously injured? (motor vehicle, hard falls, broken bones…)
_____

Do you have any dental or TMJ problems? _____

Do you have any allergies? (medications, substances, foods…) _____

List all medications, vitamins, herbs & other supplements you are currently taking: _____
_____

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PAIN EVALUATION

Time of day when pain is worst: __Morning __Afternoon __Evening __Wakes Me/Night

Does the pain radiate? _____

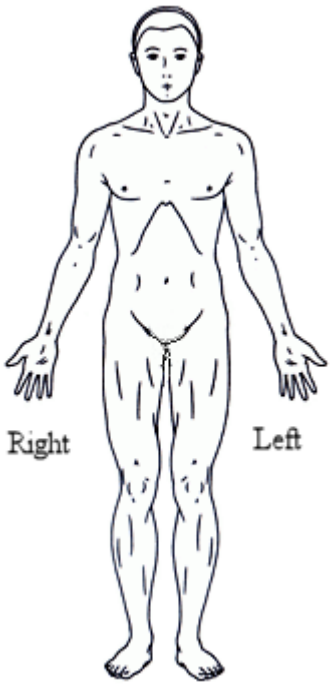
Please circle on the pain scale from 0 to 10 the pain you feel with this condition.

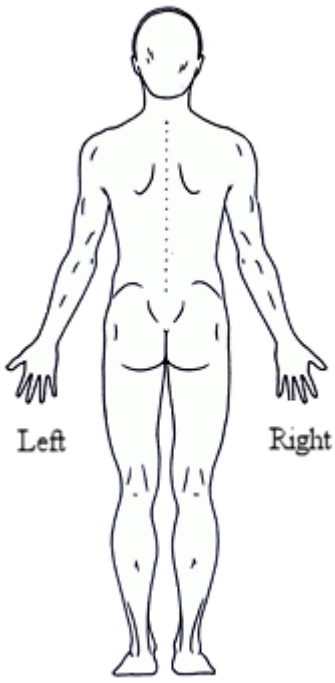
10 being the worst pain you have felt with this condition, 0 being no pain.

Mark areas of pain on figures below.

Type of Pain: (S) Stiffness (B) Burning (N) Numb/Tingling
(I) Intense/Sharp (A) Achy/Soreness (O) Other:_____

Pain Chart





Neck Pain
0 1 2 3 4 5 6 7 8 9 10

Shoulder, Arm Pain

0 1 2 3 4 5 6 7 8 9 10

Mid Back Pain
0 1 2 3 4 5 6 7 8 9 10

Low Back Pain
0 1 2 3 4 5 6 7 8 9 10

Hip, Leg Pain
0 1 2 3 4 5 6 7 8 9 10

Foot, Ankle Pain
0 1 2 3 4 5 6 7 8 9 10

Other Pain
_____
_____

****PLEASE MARK & EXPLAIN ALL PLACES THAT HAVE EVER BEEN INJURED****
(sprains/strains, broken bones, severe bruises, surgery, scars, cuts, burns, head trauma, etc.)

WHAT HAPPENED?	WHEN DID IT HAPPEN?

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FAMILY HISTORY

Please list age(s) and health problems (if any); if deceased, please list age at death and cause of death:

Father _____ Mother _____

Grandparents _____ Children _____

Brothers _____ Sisters _____

LIFESTYLE & HABITS

When was your last physical exam? _____ Blood Tests _____
(please remember to bring copies of any tests and/or reports, ie. Blood, Cholesterol, X-Ray, MRI, etc.)

Describe your use of: Cigarettes/Tobacco _____ Alcohol _____
Other drugs/substances _____

Describe your present exercise habits & physical activities you participate in: _____
(Include frequency per week, duration, & heart rate) _____
_____

*How many hours per night do you sleep on average? _____ *Do you fall right asleep? YES NO

*Do you sleep through the night without waking? YES NO *Do you remember your dreams? YES NO

*Do you have nightmares? YES NO *Do you have night sweats? YES NO *DO you snore? YES NO

*Do you wake up feeling refreshed? YES NO *What is your daily energy level? (1 low - 10 high) _____

What are the major stressors in your life? _____
_____

Are you willing to change your diet if it will improve your symptoms? YES NO MAYBE

Are you willing to do daily exercises to improve your condition? YES NO MAYBE

How much time can you invest? 15 min 30 min 45 min 1 hr +

By signing this form, I give consent to receive treatment from the physician and employees at True Health. I also certify that this information is accurate & complete to the best of my knowledge, and I agree to notify the doctor or his staff of any changes in my condition, symptoms, and/or treatment.

_____ _____
Patient Signature **Date**

_____ _____
True Health Employee **Date**

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Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__ Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy _____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
__ Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes. I agree to allow this office to examine me for further evaluation and treatment.

Patient Signature_____ **Date**_____

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OTHER PERTINENT INFORMATION

*Please include any other info you believe would be helpful in your overall evaluation and treatment.

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