New Patient Intake Form

Morganton Chiropractic, PLLC
512 N Green St.
Morganton, NC 28655
(828)544-5426
morgantonchiropractic@gmail.com

(If under 18, add Legal Guardians Contact Information as well)

MM DD YYYY

First Name:	Last Name:	Date Of Birth:

Home Phone:	Mobile Phone:	Work Phone:

@E-Mail:	Gender: ♀ Female ♂ Male

Street Address:	Apt/Suite #:

City:	ZipCode:	State:

PLEASE READ

By signing below on page 3 of this intake form, I am confirming the following:

I understand that Morganton Chiropractic, PLLC is a cash practice.

I understand that I am financially responsible for all services and products rendered to the above named patient at the time of said service or product transaction.

Emergency Contact Name:	Phone:	Relationship:

Primary Care Provider Name:	Phone:

Street Address:	Apt/Suite #:

City:	ZipCode:	State:

Employer/Company Name:	Phone:

Street Address:	Apt/Suite #:

City:	ZipCode:	State:

Job Title/Position:	Currently Working: ❑ Yes ❑ No ➪ Date Stopped Working:

Health Detail

Reason For Your Visit

MM DD YYYY

☐ Wellness & Health Maintenance		
☐ Injury, Pain Complaint, or Ailment	Date Of Injury (When Did Your Pain Start?)	
☐ Accident ☐ Automobile Related Accident ☐ Other Type Of Accident	Date Of Accident: MM/DD/YYYY	State: Where Accident Occurred MM/DD/YYYY
Please Provide Brief Details Of Your Injuries & Pain:		

Referral ***

☐ I Was Referred By a Current Patient

☐ I Was Referred By My Primary Care Physician or Another Doctor

Referring Name:		Phone:
Street Address:	Apt/Suite #:	@ E-Mail:
City:	ZipCode:	State:

Representative Details

(If You Are Being Represented By An Attorney For An Accident Please Provide Info)

Referring Provider Name:		Phone:
Street Address:	Apt/Suite #:	@ E-Mail:
City:	ZipCode:	State:

Previous Chiropractic Care

☐ Yes ☐ No

Who/Where:	Last Adjustment Date:

Health History

Lifestyle

MM DD YYYY

Are You A Smoker? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week
Do You Drink Alcohol? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week
Do You Exercise? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week

Have You Ever Been Hospitalized? ❑ Yes ❑ No	Have You Had Any Surgeries? ❑ Yes ❑ No
If Yes, Please List Dates/Details:	

Do you have any allergies? ❑ No	Do you have any diagnosed health issues? (High Blood Pressure, Diabetes etc.) ❑ No
If Yes, Please Provide Details:	

Do You Take Any Medications? ❑ Yes ❑ No
Please List All Medications & Dosage (How Much & How Often?)

Please Provide Any Other Information in Regards to Falls, Fractures, and Past Accidents (Including Motor)

_____ _____

Patient/Parent Signature Date

If Medicare/Medicaid beneficiary, signature also required on Refusal to Allow Submission of Billing to Insurance Form

Morganton Chiropractic

Affordable Family Care

Jordan P. Johnson, DC
512 N. Green St. Morganton, NC 28655
Tel. 828-544-5426

INFORMED CONSENT FOR EXAMINATION, TREATMENT, & PRIVACY PRACTICES

I hereby request and consent to the performance of examination and treatment on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic Dr. Jordan P. Johnson and/or other licensed doctors of chiropractic who now or in the future work at Morganton Chiropractic, PLLC or any other office or clinic. Treatment includes chiropractic manipulation/adjustments and other chiropractic procedures, including various modes of physiotherapy, soft-tissue therapy, rehabilitative therapy and/or referral for diagnostic tests as necessary,

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

The Notice of Privacy Practices has been made available to me and I consent to the use or disclosure of my protected health information for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my care or to conduct health care operations of this office. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information and my rights and duties of this office with respect to my protected health information

Patient Name	Patient Signature	Date

If Patient is a Minor:

Parent/Guardian Name	Relationship to Patient	Date