

**Personal Information**

Full Name \_\_\_\_\_ SSN \_\_\_\_\_ Today's Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ ext. \_\_\_\_\_ (C) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Marital Status \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Email \_\_\_\_\_  
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 \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Identification # \_\_\_\_\_ Group # \_\_\_\_\_  
**Secondary Insurance Company** \_\_\_\_\_  
Insured Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
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 a 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 Dr. Morgan's Complete Health Center Office Policies and Procedures.**

\_\_\_\_\_  
Patient or Legally Authorized Individual Signature  
\_\_\_\_\_  
Date  
  
\_\_\_\_\_  
Print Patient's Full Name  
\_\_\_\_\_  
Date  
  
\_\_\_\_\_  
Witness  
\_\_\_\_\_  
Date

**Primary Concern**

What is your reason for today's visit? \_\_\_\_\_  
\_\_\_\_\_

Date of first occurrence \_\_\_\_\_ Date of most recent occurrence \_\_\_\_\_

Is your condition the result of an accident (please explain) \_\_\_\_\_

Have you had this or similar conditions in the past? \_\_\_\_\_

What makes it better? \_\_\_\_\_ Worse? \_\_\_\_\_

How would you describe the pain (burning, sharp, stabbing, dull, etc) \_\_\_\_\_

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

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

Is the condition constant? \_\_\_\_\_ Does it come and go (explain) \_\_\_\_\_

Is this condition interfering with work/school? \_\_\_\_\_ Sleep? \_\_\_\_\_ Activity? \_\_\_\_\_

Please list your goals for treatment (immediate and 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 illness you have had if not previously mentioned \_\_\_\_\_

List all surgeries with dates & results \_\_\_\_\_  
\_\_\_\_\_

Have you ever been in an accident or seriously injured (explain) \_\_\_\_\_  
\_\_\_\_\_

Do you have any dental or TMJ problems \_\_\_\_\_

List all medications, vitamins, herbs and other supplements currently taking \_\_\_\_\_  
\_\_\_\_\_

List all medications and other substances (i.e. foods) you are allergic to \_\_\_\_\_  
\_\_\_\_\_

Please Turn Over



## Symptom Survey

Please circle any of the following symptoms/conditions you have had or are currently experiencing.

### Gastro-Intestinal

Digestive complaints  
Stomach pain  
Heartburn  
Nausea  
Diarrhea  
Constipation  
Irritable bowel  
Black or bloody stool

### Blood Sugar

Sleepy after meals  
Bloating after meals  
Poor concentration after meals  
High blood pressure  
Always hungry  
Irritable if skipped meals  
Irritable before meals  
Crave sweets  
Feelings of depression

### Thyroid

Increased body fat/weight  
Chronic fatigue  
Slow metabolism  
Cold hands & feet  
Hair coarse/unmanageable  
Reduced initiative  
Very difficult to get up in a.m.  
Depression

### Genito-Urinary

Kidney or bladder infections  
Kidney stones  
Bladder leaks too easily

### Dysbiosis

Fatigue or lethargy  
Poor memory  
Frequently sick  
Feeling spacey, brain fog  
Irritability; moodiness  
Depression  
Food sensitivities  
Chemical sensitivities  
Constipation or diarrhea  
Chronic pain  
Insomnia  
Headaches/sinusitis  
PMS  
Chronic rashes/itching

### Structural/Neurological

Headaches  
Muscle cramps/spasms  
Neck pain  
Jaw pain  
Dizziness  
Back pain  
Shoulder/elbow/wrist pain  
Knee/hip pain  
Osteoporosis

### Immune Response

Chronic cough  
Asthma  
Recurrent head colds  
Recurrent sinus infections  
Recurrent bronchitis  
Smoker

### Adrenal

Chronic fatigue  
Dizziness upon standing  
Crave sugary foods  
Allergies or asthma  
Low blood pressure  
Sensitive to bright light  
Sexual desire reduced  
Insomnia/wake during night  
Low back/knee/ankle problem  
Tired in early afternoon  
Caffeinated beverages  
consumed per day \_\_\_\_\_

### For Women Only

Urinary tract infections  
Yeast infections  
Vaginal discharge  
Menstrual irregularity  
Cramping  
Mood swings/depression  
Pre-menstrual syndrome  
Hot flashes  
Currently on hormone meds  
Currently on birth control

### Fatty Acid Imbalance

Burning type of pain  
Aspirin/NSAIDs reduce pain  
Chronic/recurrent inflammation

### Cardiovascular

History of anemia  
History of high cholesterol  
High or low blood pressure  
Chest pain  
Previous heart trouble  
Poor circulation