MORRIS CHIROPRACTIC GROUP

426 Morris Avenue Elizabeth, NJ 07208 Tel: 908.469.4070 Fax: 908.469.4068

Dr. Monica Gonzalez

Please fill out the following in as much details as possible

Please Print (BLACK INK ONLY)

Date_____

Name_____

Address_____

City_____State_____Zip_____

Home Phone_____Office Phone_____

E-Mail Address_____

Age_____Date of Birth_____Occupation_____Sex___ (F) ___(M)__

Weight_____Referred by_____

Employed_____Address_____

Married_____S___W__Children_____Name of Spouse_____

Who should we contact in case of an emergency? _____ Ph: _____

Is any other member of the family being treated in this office? _____

Have you ever had chiropractic care before? _____

For what problem? _____

Were the results satisfactory? Yes_____ No_____ N/A_____

Major complaints and symptoms-please be as specific as you can. Ask the doctor or nurse for help if you need assistance filling out this section

_____

_____

How do you believe your problem (pain) began?_____

_____

Have you lost any work? _____Day and date you last worked_____

Have you ever had this conditions before or similar condition? _____

When? _____

What positions or activities aggravate you condition? _____

What positions or activities relieve your condition? _____

Have you ever been treated by a Medical Physician for this ailment? _____

Where? _____

Describe the type of treatment_____

Diagnosis or previous physician_____

Length of time under care_____Results_____

Family physician's name_____

Please send a report to my family physician Yes___ No__

Will this case be covered by any insurance company?

Major Medical____ Auto____ Blue Cross/Blue Shield____

Workers Compensation_____ Medicare_____ Other___

Have you ever been in any auto accident, Fall down stairs; fall down ladder (even as a child)? _____When_____

Are you allergic to anything you are aware of/ _____

Are you presently taking any medication, herbs, or over-the counter products (aspirin included)? Yes____ No____

If yes, name them_____

What operations have you had? _____Year_____

_____Year_____

_____Year_____

Have your ever had any cosmetic surgery, breast implants, ect? _____Year_____

Have you had any surgery to replace hip, knee, etc.?_____

Gives dates you have had any of the following? (If exact date is unknown, give approximate.)
Blood
Test_____Urinalysis_____
Radiation Treatment_____ X-Rays examination_____
Other special treatment_____
At what hospital or office were these tests taken _____
Name of the doctor who ordered test_____
Dates of last menstrual period_____
Do you have any health problems not listed above? _____
Do you whish to have a third person or chaperone present during your examination and treatment? Yes____ No____
Do you faint easily? _____
Do you take vitamins? Yes____ No____ If yes, please list them_____
Do you exercise regularly? Yes____ No____ What kind of exercise?
_____
Habits: (Please check)
Cigarettes_____ Quantity_____ Coffee? _____ Quantity_____
Alcohol? _____ Quantity_____ Tea? _____ Quantity_____
Hobbies_____
Have you been treated for any health condition by a physician in the past year? _____
If yes, what conditions? _____
Have you lost or gained weight in the past year? _____
Use this space for any additional information you may wish to discuss_____
_____
_____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter N if you have these conditions now (within the past 12 months) or P if you had these conditions in the past.

	Now N	**Past P**		**Now N**	**Past P**
Headaches Frequently	____	____	Loss of Balance	____	____
Neck Pain	____	____	Fainting	____	____
Stiff Neck	____	____	Loss of Smell	____	____
Sleeping Problems	____	____	Lost of Taste	____	____
Back Pain	____	____	Diarrhea	____	____
Nervousness	____	____	Feet Cold	____	____
Tension	____	____	Hand Cold	____	____
Irritability	____	____	Arthritis	____	____
Chest Pains	____	____	Muscle Spasms	____	____
Dizziness	____	____	Frequent of Colds	____	____
Shoulder/Neck/Arm Pain	____	____	Stomach Upset	____	____
Pins & Needles in Arms	____	____	Constipation	____	____
Pins & Needles in Legs	____	____	Cold Sweats	____	____
Numbness in Fingers	____	____	Fever	____	____
Numbness in Toes	____	____	Sinus Problems	____	____
High Blood Pressure	____	____	Diabetes	____	____
Difficulty Urinating	____	____	Hemorrhoids	____	____
Allergies	____	____	Leg Cramps	____	____
Weakness in Arms	____	____	Colitis	____	____
Weakness in Legs	____	____	Gall Bladder	____	____
Shortness of Breath	____	____	Indigestion	____	____
Fatigue	____	____	Belching	____	____
Depression	____	____	Vomiting	____	____
Lights Bother Eyes	____	____	Shoulder Pain	____	____
Loss of Memory	____	____	Swelling Joints	____	____
Ears Ring	____	____	Knee Pain	____	____
Face Flushed	____	____	Hay fever	____	____
Buzzing in Ears	____	____	Menstrual Difficulties	____	____

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charged directly to me, and that I personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will immediately due and payable.

PATIENT SIGNATURE_____

SOCIAL SECURITY NUMBER_____DATE_____