everhealth
CHIROPRACTIC
7114 Shady Oak Rd Eden Prairie, MN 55344

ABOUT THE PATIENT

Name _____ **Today's Date**_____ **Birthdate** _____ **Age**_____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____**Gender** ❑ **M** ❑ **F**

Significant Other's Name _____ **Kid's Names and Ages** _____

Your Employer _____ **Type of Work** _____

E-Mail Address _____ **Have you been to a chiropractor before?** □ **No** □ **Yes**

Emergency Contact _____ **ph #** _____

How did you hear about us? _____

Name of Medical Doctor(s)_____

- **I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.**
- **I authorize EverHealth to release and / or request records to or from other providers as may be necessary.**
- **I understand I am responsible for all bills incurred in this office.**
- **I authorize assignment of my insurance benefits (if applicable) directly to the provider.**
- **Person responsible for this account if other than the patient?** _____
- **I understand that after any initial promotional services all care is rendered at usual and customary fees.**
- **For my balance my preferred payment method is:** ❑ **Cash** ❑ **Check** ❑ **Credit Card** ❑ **Car/Work Ins.**

_____ _____

Patient / Parent Signature **(This represents a long term authorization for all occasions of service)** **Date**

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ **How long has this been an issue?** _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ **How long has this been an issue?** _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ **How long has this been an issue?** _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ **How long has this been an issue?** _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

_____

6. What makes it better? _____

7. What makes it worse? _____

8. What Doctor's have you seen for this? _____

_____

9. Type of treatment: _____

10. Results: _____

NOTES: _____

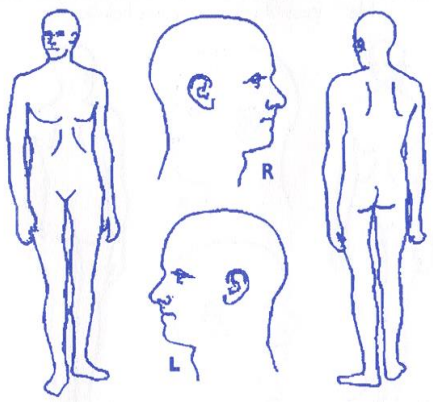
_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark all areas of concern.



Patient Name_____ ***Mark the conditions that apply to you.***

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. List any medications you are taking:_____

_____

2. Please list all doctors you are currently seeing: _____

_____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name____

_____

_____

PAST HISTORY

4. List any past auto collisions:_____ **Was any care received?**_____

5. List any past work injuries: _____ **Was any care received?**_____

6. List any past sport, recreational, or home injuries_____

7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

Paying for your care is easy here!

Mark and initial which one is you:

everhealth CHIROPRACTIC

❑ **No Insurance**: • Easy! Our Care Plans and simple payment arrangements have helped over 4000 people and will work great for you too!

*Initial*_____

❑ **Health Insurance:** • These days, insurance pays very little if anything for natural drugless care to get you healthy. So we make it easy!

• We will verify any benefits you may have and send your claims in to your insurance for you.

• If they pay anything after your deductible is met, we will accept payment directly from them.

• You are responsible for any deductible, co-insurance, co-pays and unpaid visits.

• Of course you can use your HSA, HRA and Flex dollars here!

• For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.

*Initial*_____

❑ **Auto Injury** • Auto related injuries are covered 100% in Minnesota. Even if you were at fault or were a passenger. You can get the care you need and it costs you ____$0____. Great for you!

• All we need is your claim number, insurance, and attorney info.

*Initial*_____

❑ **Work Injury** • Work injuries are covered 100% for up to 12 weeks of care.

• All we need is your claim number and Work Comp ins. info.

*Initial*_____

❑ **Medicare** • Regardless of your condition, Medicare pays for up to a maximum of 12 weeks of care. They have very strict rules and limitations.

• After this you will receive a significant Medicare discount.

We simply need a copy of your Medicare card.

• Medicare supplements normally don't pay anything.

*Initial*_____