



CHIROPRACTIC

480 W. 78<sup>th</sup> St. Ste. 101A Chanhassen, MN 55317

# 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 authorize the use of my name, image, voice & testimony to be used in photographic, audio, video or written form.
- 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? \_\_\_\_\_

\_\_\_\_\_

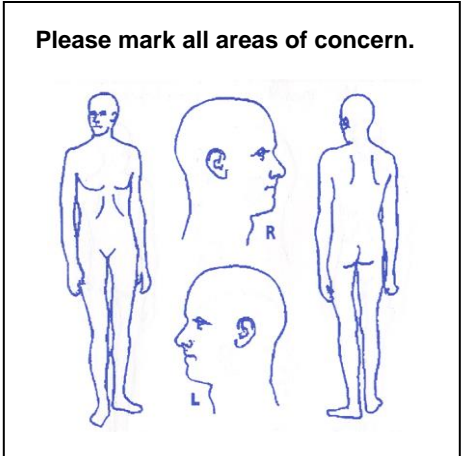
9. Type of treatment: \_\_\_\_\_

10. Results: \_\_\_\_\_

NOTES: \_\_\_\_\_

\_\_\_\_\_

**Are you pregnant?**  
 Yes  No





CHIROPRACTIC

# GENERAL HEALTH HISTORY

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Patient Name \_\_\_\_\_ *Mark the conditions that apply to you.*

**Past Present**

- Headaches
- Migraines
- Shortness of Breath
- Allergies / Asthma
- Medication Side Effects
- Diabetes
- Hands or Feet cold
- Muscle aches
- Trouble Walking
- Leg / Foot Numbness
- Fainting
- Gall Bladder Trouble
- Ringing in Ears
- Ear Problems
- Sleeping Problems
- Vision Problems
- Thyroid Problems
- Liver Disease
- Kidney Problems
- Light Bothers Eyes
- Other \_\_\_\_\_

**Past Present**

- Urinary Problems
- Easy Bruising
- Tobacco Use
- Dental Problems
- Fibromyalgia
- Blood Thinner use
- HIV Positive
- Cancer
- Depression
- Alcohol Use
- \_\_\_High or \_\_\_Low Blood Pressure
- Stroke History
- High Cholesterol
- TMJ
- Digestive Problems
- Pain all Over
- Tension / Irritability
- Chest Pains
- Heart Pacemaker
- Heart Problems

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? \_\_\_\_\_



**Mark and initial which one is you:**

**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* \_\_\_\_\_