Application for Care: Minnesota Family Chiropractic

PATIENT DEMOGRAPHICS

Name: ______________________________ Birth: ____-____-_____ Age: _____ ☐ Male ☐ Female

Address: _______________________________ City: _________________ State: ________ Zip: ________

E-mail Address: _______________________ Home Phone: _____________ Mobile Phone: ____________

Marital Status: ☐ Single ☐ Married ☐ Partner Do you have insurance? ☐ Yes ☐ No

Social Security #: ______________________________ Driver's License #: __________________________

Employer: ___________________________________ Occupation: ________________________________

Spouse's Name ___________________________ Spouse's Employer ______________________________

Number of Children and Ages: ____

Name & Number of Emergency Contact: _____________________________ Relationship: _____________

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____________________________

Secondarily: ______________________ Third: _______________________ Fourth: ___________________

On a scale of 1 to 10 with 10 being the worst pain and zero being no pain, rate your above complaints by circling the number:

Primary or chief complaint is:	1 -	2 -	3 -	4 -	5 -	6 -	7 -	8 -	9 -	10
Second complaint is:	1 -	2 -	3 -	4 -	5 -	6 -	7 -	8 -	9 -	10
Third complaint is:	1 -	2 -	3 -	4 -	5 -	6 -	7 -	8 -	9 -	10
Fourth complaint is:	1 -	2 -	3 -	4 -	5 -	6 -	7 -	8 -	9 -	10

When did the problem(s) begin? ___________________

When is the problem worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? Constant? OR on and off during the day? OR It comes and goes throughout the week? ____

How did the injury happen? ____

Condition(s) ever been treated by anyone in the past? YES or NO If YES, when: ______ by whom? _____

How long were you under care: _______________________What were the results? _________________

Name of Previous Chiropractor: ____

Patient Name ________________________ File#/HRN _______________ Date____________________

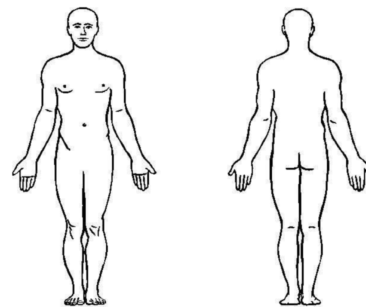
- PLEASE MARK the areas on the Diagram with the following letter to describe your symptoms:

  R= Radiating **B**= Burning **D**= Dull **A**= Aching

  N=Numbness **S**= Sharp/Stabbing **T**= Tingling

  What relieves your symptoms? _______________________

  What makes them feel worse? _______________________



LIST RESTRICTED ACTIVITY: CURRENT ACTIVITY LEVEL: USUAL ACTIVITY LEVEL:

___________________________: ____

___________________________: ____

___________________________: ____

Is your problem the result of ANY type of accident? YES or NO

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

____

____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? YES or NO If YES, how many times? _

When was the last episode? ______________________ How did the injury happen? ___________________

Other forms of treatment tried: ☐ Yes ☐ No If yes, how many times? __________________________

and who provided it: _______________________ How long ago? ___________________________________

What were the results? ☐ Favorable ☐ Unfavorable Explain: ______________________________

Please identity any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for Past, **C** for Currently have or **N** for Never have had:

___ Broken Bone ___ Dislocations. ___Tumors. ___Rheumatoid Athritis ___Fracture. ___Disability

___ Cancer ____Osteo Arthritis ___ Diabetes. ____ Cerebral Vascular ____ other serious conditions

Patient Name ________________________ File#/HRN _______________ Date____________________

PLEASE Identify ALL PAST and any CURRENT conditions you feel may be contributing to your condition:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
CHILDHOOD DISEASES			
ADULT DISEASES			
INJURIES			
SURGERIES			

SOCIAL HISTORY

1. Smoking: __ Cigars ___ Pipe ___ Cigarettes

   How often? ___ Daily ___Weekends ___ Occasionally ___ Never
2. Alcoholic Beverage consumption occurs

   ___ Daily ___Weekends ___ Occasionally ___ Never
3. Recreational Drug Use:

   ___ Daily ___Weekends ___ Occasionally ___ Never

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? YES or NO

   If yes whom: ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Sister(s) ☐ Brother(s) ☐ Son(s) ☐ Daughter(s)
2. Any other hereditary conditions the doctor should be aware of > ______________________________

I hereby authorize payment to be made directly to MN Family Chiropractic, for all benefits which may be payable under a healthcare plan or from any other sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Minnesota Family Chiropractic for any and all services I receive at this office.

____ ______-______-_______

Patient or Authorized Person's Signature Date Completed

____ ______-______-_______

Doctor's Signature Date Completed

Patient Name ________________________ File#/HRN _______________ Date____________________

INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? ____
- How many auto accidents have you been in? ____
- What speed was the collision? ____
- Type of Impact: Front Impact / Side Impact / Rear Impact ____
- Was treatment received? ____

When was your most recent strain at work? ____
- Please describe the manner of injury ____
- Was treatment received? Please describe ____
- Does your job require you to remain in long term stressful postures? ______________________ (i.e., all day sitting, repeated liftin, long term computer use)

Spinal traumas in the past? ____
- Collisions, quick burst, or repetitive motions sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field____
- Trauma as a child i.e., fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident____
- Work around the house—lifting, bending, woke up with a stiff neck, “back went out” ____________________

Please mark P for in the Past, C for Currently have, or N for Never

___ Headache	___ Pregnant (Now)	__ Dizziness	__ Prostate Problems	__ Ulcers
___ Neck Pain	___ Frequent Colds	__ Loss of Balance	__ Sexual Dysfunction	__ Heartburn
__ Jaw Pain, TMJ	___ Convulsions	___ Fainting	__ Digestive Problems	__ Pelvic Floor Dysfunction
__ Shoulder Pain	___ Tremors	___ Double Vision	___Colon Trouble	__ High Blood Pressure
__ Upper Back Pain	__ Chest Pain	___ Blurred Vision	__ Diarrhea	__ Low Blood Pressure
__ Mid Back Pain	__ Pain w/ Coughing	___ Ringing in Ears	__ Menopausal Problems	__ Asthma
__ Low Back Pain	__ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problems	__ Difficulty Breathing
__ Hip Pain	__ Sinus/ Drainage Problems	___ Depression	___ PMS	__ Lung Problems
__ Back Curvature	__ Swollen/ Painful Joints	__ Irritability	__ Bed wetting	__ Kidney Trouble
__ Scoliosis	__ Skin Problems	__ Mood Changes	__ Learning Disability	__ Gall Bladder Trouble
__ Numb/ Tingling arms, hands, fingers	__ ADD/ADHD	__Eating Disorder	__ Skin Problems	__ Eating Disorder __ Hepatitis (A,B,C)
	__Liver Trouble	__Allergies	__ Trouble Sleeping	
__ Urinary Incontinence				

Patient Name ________________________ File#/HRN _______________ Date____________________

Activities of Daily Living/ Symptoms/ Medications

Daily activities: Effects of Current Conditions on Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Concentrating	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Doing Computer Work	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Gardening	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Playing Sports	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Recreation Activities	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Shoveling	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Sleeping	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Watching TV	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Carrying	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Dancing	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Dressing	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Lifting	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Pushing	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Rolling Over	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Sitting	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Standing	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Working	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Climbing	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Doing Chores	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Driving	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Performing Sexual Activity	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Reading	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Running	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Sitting to Standing	No Effect	Painful (can do)	Painful (limits)	Unable to Preform
Walking	No Effect	Painful (can do)	Painful (limits)	Unable to Preform

Please list all Medication and Dosages:

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____

Patient Name ________________________ File#/HRN _______________ Date____________________

Minnesota Family Chiropractic - Informed Consent and Privacy to Practice

Regarding Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Minnesota Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do Hereby consent to treatment by any means, methods, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Regarding Patient Privacy Notice:

I have received a copy of Minnesota Family Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these tights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

____ ____/____/____ [ ] *Witness Initials*

Patient or Authorized Person's Signature Date

Patient Name ________________________ File#/HRN _______________ Date____________________

Regarding X-rays/ Image Studies

FEMALES ONLY – *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

- ☐ The first day of my last menstrual cycle was on ___-___-___ (date)
- ☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and/or a member of the staff has discussed with me that hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date