BURTIS CHIROPRACTIC CENTER
PERSONAL INJURY WAIVER

TODAY'S DATE: _____

First Name: _____ **Middle Name:**_____ **Last Name:**_____

Address:_____

City: _____ **State:**_____ **Zip:**_____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Date of Birth: _____/_____/_____ **Social Security #:** _____-_____-_____

Gender: [male] or [female]

MARITAL STATUS: Single / Married / Divorced / Widowed / Other

Spouse's Name: _____ Number of Children: _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail / Text Message
***** 1 day before appointment or 2 hours before appointment***

Cell Phone Carrier (Circle one): Verizon / Sprint / AT & T / Virgin Mobile / Other _____

EMERGENCY CONTACT
Name: _____
Relationship: _____
Phone: _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?
Did someone refer you here? [YES] or [NO]
If yes, name: _____
Did you hear or see us in an Advertisement? [YES] or [NO]
If yes, where: _____

EMPLOYMENT (or parent's employment for minors)
Regular Work Status: (*circle one*)
EMPLOYED / PART-TIME EMPLOYED / RETIRED / UNEMPLOYED / FULL-TIME STUDENT / PART-TIME STUDENT
Employer/School Name: _____
Employer City and State: _____
Occupation: _____ Employer Phone #:_____

PREVIOUS CHIROPRACTIC CARE EXPERIENCE
Have you had previous Chiropractic Care? [YES] or [NO]
If yes, reason for visit: _____ _____
Doctor's name: _____ Date of last chiropractic visit: _____

CURRENT SYMPTOMS
Purpose of visit today: [ ] Wellness [ ] Complaint [ ] Injury [ ] Other: _____
If an injury, where did the injury occur? [ ] Automobile [ ] Work [ ] 3rd Party Premise [ ] Other

Date of Injury: _____

Location of Accident: _____

Were you the: [ ] DRIVER OR [ ] PASSENGER

Was anyone else with you in the vehicle: _____ Do you have insurance on your vehicle?_____

Burtis Chiropractic Center
112 N. State Street
Fairmont, MN 56031
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POLICY HOLDER: _____ POLICY #: _____

INSURANCE COMPANY: _____

ADDRESS: _____

CLAIM #: _____

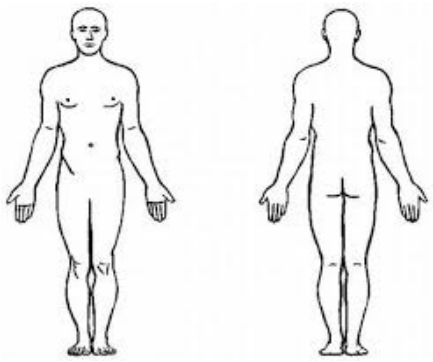
HAVE YOU RECEIVED CARE ANYWHERE ELSE? _____ YES _____ NO
IF YES – WHERE: _____ WERE X-RAYS TAKEN? _____ YES _____ NO

Describe how the injury happened: _____
_____

_____

Rate your pain on a scale of 1-10: (1 being the least pain and 10 is the maximum pain)
At its best: _____ At its worse: _____ Current level: _____

Please indicate the areas affected by the injury:



Describe the pain/discomfort you are feeling and where: (i.e. numbness in right arm, shooting pains from hip down left leg, back pain more on left or right side)

_____

_____

_____

Indicate the areas of your life it has impacted:

[ ] Work [ ] Daily Activities [ ] Sleep [ ] Appetite [ ] Other

Please describe: _____

Frequency you are experiencing pain from this condition?

[ ] Always [ ] Hourly [ ] Daily [ ] Occasionally

Has this concern:

[ ] Gotten Worse [ ] Stayed Constant [ ] Come and Gone

Have you reduced or limited your work hours because of this condition? [YES] or [NO]

If yes, explain: _____

Is your pain/discomfort worse at certain times of the day? [YES] or [NO]
If yes, when: _____

List anything that aggravates your condition: _____

_____

List anything that relieves or improves your condition: _____

_____

Have you seen any other doctors for this concern? [YES] or [NO]
If yes: Doctor's name: _____ Where: _____
Type of Treatment: _____ X-rays/MRI taken? [YES] or [NO]
Results: [GOOD] [BAD] OR [INDIFFERENCE]

PERSONAL INCIDENT HISTORY

Broken any bones? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]
Briefly explain: _____

Had any major sprains or strains? [YES] or [NO]
If yes, did you get professional treatment? [YES] or [NO]
Briefly explain: _____

Been hospitalized? [YES] or [NO]
Briefly explain: _____

Had surgery? [YES] or [NO]
Briefly explain: _____

Been in a previous Auto Accident? [YES] or [NO]
If yes, did you get professional treatment? [YES] or [NO]
Briefly explain: _____

Been Struck Unconscious? [YES] or [NO]
If yes, did you get professional treatment? [YES] or [NO]
Briefly explain: _____

Been diagnosed with an eating disorder? [YES] or [NO]
Briefly explain: _____

Had a stroke? [YES] or [NO]
Briefly explain: _____

FAMILY HEALTH HISTORY

List diagnosed health conditions and untimely deaths of your blood-related family members:

(*Condition and relationship to you*) (ex: arthritis, cancer, diabetes, heart disease, high blood pressure)

_____

_____

SOCIAL HISTORY AND LIFE CHOICES

Alcohol:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Diet Food Products:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Energy Products & Over-the-Counter Stimulants:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Caffeine Drinks & Products:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Soft Drinks:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Water:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Fresh & Homemade Foods:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Preprocessed, Packaged, & Restaurant Food:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Exercise:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never
Tobacco:	[ ] Daily	[ ] Weekly	[ ] Occasionally	[ ] Never

HEALTH PROBLEMS AND CONCERNS

Please check all that you have had or currently have.

[ ] Allergies	[ ] Cramps	[ ] Hot Flashes	[ ] Sciatica
[ ] Alcoholism	[ ] Dementia/Alzheimer's	[ ] Irregular Heart Beat	[ ] Seizures
[ ] Anemia	[ ] Depression	[ ] Irregular Menstrual Cycle	[ ] Shortness of Breath
[ ] Arteriosclerosis	[ ] Diabetes	[ ] Kidney Infection	[ ] Sinus Infection
[ ] Arthritis	[ ] Digestion Problems	[ ] Kidney Stones	[ ] Sleep Problems/Insomnia
[ ] Asthma	[ ] Diagnosed emotional/	[ ] Liver disease/cirrhosis	[ ] Skin Sensitivity
[ ] Autoimmune Disease	mental disorders	[ ] Loss of Memory	[ ] Spinal Curvatures
[ ] Back Pain	[ ] Dizziness	[ ] Loss of Balance	[ ] Stroke
[ ] Bleeding Disorders	[ ] Epilepsy	[ ] Loss of Smell	[ ] Swelling of Ankles
[ ] Breast Lump	[ ] Excessive Menstruation	[ ] Loss of Taste	[ ] Swollen Joints
[ ] Bronchitis	[ ] Eye Pain or Difficulties	[ ] Lung disease	[ ] Thyroid Condition
[ ] Bruise Easily	[ ] Fatigue	[ ] Macular Degeneration	[ ] Tuberculosis
[ ] Cancer	[ ] Frequent Urination	[ ] Migraines	[ ] Ulcers
[ ] Cataracts	[ ] Gallbladder disease/	[ ] Nosebleeds	[ ] Varicose Veins
[ ] Chest Pain	stones	[ ] Pacemaker	[ ] Venereal Disease(STD)
[ ] CHF (congestive heart disease)	[ ] Glaucoma	[ ] Parkinson's	[ ] Other:
[ ] Cold Extremities	[ ] Gout	[ ] Polio	_____
[ ] Constipation	[ ] Headache	[ ] Poor Posture	_____
[ ] COPD/emphysema	[ ] Hemorrhoids	[ ] Prostate Trouble	_____
[ ] CVA (stroke/TIA)	[ ] High Blood Pressure	[ ] Retinal Disease	

AUTHORIZATION

I certify that I'm the patient or legal guardian listed below. I understand the information given on this intake form is true and accurate to the best of my knowledge. I consent to the collection and use of that information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions.

☐ I agree with this statement of authorization.

Name (Please Print): _____

Patient's Signature: _____ **Date:** _____

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