Eastlund Chiropractic Clinic
3035 White Bear Ave. N., Suite 10
Maplewood, MN 55109
651.779.9282

PATIENT INFORMATION

Date _______________ Name ______________________________Nickname:_________

Address _______________________________________ City ______________________

State __________ Zip Code _____________________ Home Phone _________________

Cell Phone ____________________ Cell Carrier _____________

Sex _______Date of Birth ______________ Married ____ Spouse's Name _______________
Widowed _____ Single _____Divorced _____

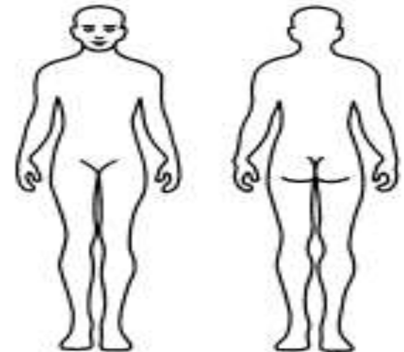
Email ____

Your Employer ____________________Occupation____________

Emergency Contact Name and Phone Number

____

Shade the areas of your pain on the diagram to the right



Reason for Visit?

____

Is condition getting progressively worse? Yes or No
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain). ___________

How long have you had this pain? ____
Is the pain constant, fluctuate in intensity, or does it come and go?
____

Does it interfere with: Work _____Sleep ____Daily Routine _____ Recreation_____
Activities or movement that are painful to perform: Sitting _____Standing _____
Walking ____Bending _____Lying down _____.

Are you currently pregnant? ____Yes____No

What treatment if any have you already received for your condition? _____________
____

ACCIDENT INFORMATION

Is condition due to an automobile accident? _____Yes _____No Date ___________
Is condition due to a work injury? _____Yes _____No Date ___________

*Date of last Physical Exam: __________________________
Are you currently under the care of another physician or specialist? _____Yes _____No

ALLERGIES: __________________________ If none, indicate "none."

MEDICATIONS/SUPPLEMENTS: If none, indicate "none."
____

Circle to indicate if you have or had any of the following: If none, indicate "none" _________.

AIDS/HIV	Chicken Pox	Migraine Headaches	Stroke/Mini Stroke
Alcoholism	Diabetes	Mononucleosis	Suicide Attempt
Head Injury	Emphysema	Multiple Sclerosis	Thyroid Problems
Anemia	Epilepsy/Seizures	Mumps	Tonsillitis
Fractures	Osteoporosis	Tuberculosis	Vascular Problems
Appendicitis	Glaucoma	Pacemaker	Tumors, Growth
Arthritis	Heart Attack	Parkinson's Disease	Sleep Apnea
Asthma	Gout	Pinched Nerve	Ulcers
Bleeding Disorders	Heart Disease	Pneumonia	Cataracts
Atrial Fibrillation	Hepatitis	Chest Pain	Autoimmune Disease
Bronchitis	Hernia	Prostate Problem	Dizziness
Eating Disorders	Herniated Disk	Prosthesis	Cancer
High Cholesterol	Depression	Anxiety	Kidney Disease
Fatigue	Liver Disease	High Blood Pressure	Blurry Vision

Other health conditions or symptoms not listed :
____

SURGICAL HISTORY: ____

EXERCISE	WORK ACTIVITY	HABITS	
___None	___Sitting	___Smoking	Packs/Day _______
___Moderate	___Standing	___Alcohol	Drinks/Week _____
___Daily	___Light Labor	___Coffee/Caffeine	Cups/Day ________

Eastlund Chiropractic Clinic
Informed consent to Chiropractic Treatment

To the Patient: Please read this entire document and ask any questions you have prior to signing it.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy/modalities on me by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician. I further understand that such chiropractic services may be performed by Eastlund Chiropractic Clinic and/or other licensed Professionals or Physicians of Chiropractic who may treat me now or in the future at this office. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, rib strain/separations, and burns (from physiotherapy). Some patients will feel some stiffness and soreness following the first few days of treatment. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

Dizziness, nausea, flushing: These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms before, during or after your care.
Fractures: When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, your treatment plan can be modified to minimize risk of fracture.
Disc herniation or prolapse: Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.
Stroke: A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between that type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increase occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke.

I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of treatment which the physician feels are in my best interest at the time, based upon the facts then known. The Doctor will make every reasonable effort during examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor’s attention, it is your responsibility to inform the Doctor.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek care for at this facility.

____
Print Patient’s Name or Representative’s Name

______________________________________ ________________________
Signature of Patient (or Representative) **Date**

Eastlund Chiropractic Clinic
NOTICE OF PRIVACY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Print Patient's Name or Representative's Name

____

Signature of Patient or Representative

____ **Date** ______________________