**Maplewood Spine and Fitness Center**
**2599 White Bear Ave N, Maplewood, MN 55109**
**Gregory E. Eastlund, D.C. Phone 651-779-9282 Fax 651-779-8247**

## REGISTRATION AND HISTORY

*PATIENT INFORMATION*

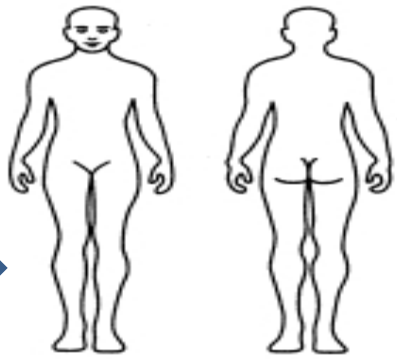
Date _____ Name _____Nickname:_____

Address _____ City _____
Zip Code _____ Phone Number _____

Cell Phone _____Cell Carrier (T-Mobile, AT&T, etc.,) _____
(*for appointment reminders)*

Email _____

Sex _____Date of Birth _____
Married ____Widowed _____ Single _____Divorced _____
Spouse's name_____
Employer _____
Occupation _____
Emergency Contact Name and Phone Number
_____



*PATIENT CONDITION*

Mark or shade in areas of pain on the diagram to the right

Reason for Visit?
_____
_____
When did your symptoms first begin? _____
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 often do you have this pain? _____
Is it constant 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.

*ACCIDENT INFORMATION*

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

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## *HEALTH HISTORY*

What treatment have you already received for your condition? _____Medications
_____Physical Therapy _____Chiropractic Services _____Other _____None
Date of last Physical Exam _____

Circle to indicate if you have had any of the following:

| | | | |
|---|---|---|---|
| AIDS/HIV | Chicken Pox | Migraine Headaches | Stroke |
| Alcoholism | Diabetes | Mononucleosis | Suicide Attempt |
| Allergy Shots | Emphysema | Multiple Sclerosis | Thyroid Problems |
| Anemia | Epilepsy | Mumps | Tonsillitis |
| Anorexia | Fractures | Osteoporosis | Tuberculosis |
| Appendicitis | Glaucoma | Pacemaker | Tumors, Growth |
| Arthritis | Goiter | Parkinson's Disease | Typhoid Fever |
| Asthma | Gout | Pinched Nerve | Ulcers |
| Bleeding Disorders | Heart Disease | Pneumonia | Vaginal Infections |
| Breast Lump | Hepatitis | Polio | Venereal Disease |
| Bronchitis | Hernia | Prostate Problem | Whooping Cough |
| Bulimia | Herniated Disk | Prosthesis | Other _____ |
| Cancer | High Cholesterol | Psychiatric Care | _____ |
| Cataracts | Kidney Disease | Rheumatoid Arthritis | _____ |
| Chemical | Liver Disease | Rheumatic Fever | _____ |
| Dependency | Measles | Scarlet Fever | _____ |

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

Are you pregnant now? ___Yes ___No Due Date _____

## *PAST MEDICAL/SURGICAL HISTORY*

| | Description | Date |
|---|---|---|
| Head Injuries | _____ | _____ |
| Broken Bones/Dislocations | _____ | _____ |
| Surgeries | _____ | _____ |

ALLERGIES YES OR NO (circle one) _____
*MEDICATIONS* (INCLUDE ANY SUPPLEMENTS) _____

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**MAPLEWOOD SPINE AND FITNESS CENTER**
**Informed consent to Chiropractic Treatment**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy 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 Maplewood Spine and Fitness Center and/or other licensed Professionals or Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with the physician and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations and sprains. 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 the procedure which the physician feels are in my best interest at the time, based upon the facts then known.

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 from to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek at this facility.

_____
Print Patient's Name or Representative's Name

_____ _____
Signature of Patient (or Representative) Date

**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.

_____ _____
Signature of Patient Date
Relationship to Patient (If applicable) _____