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 _____

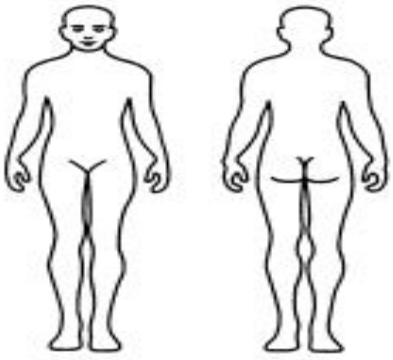
Sex _____Date of Birth _____ Married ____ Spouse's Name _____
Widowed _____ Single _____Divorced _____

Email _____ Who may we thank for referring you? _____

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 it constant, constant and fluctuates 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.

ACCIDENT INFORMATION

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

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

Date of last Physical Exam: _____

ALLERGIES: _____ If none, indicate "none."

MEDICATIONS/SUPPLEMENTS: (List below)

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	Cancer
High Cholesterol	Psychiatric Care	Cataracts	Kidney Disease
Measles	Liver Disease	Other _____	

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	_____	_____

Eastlund Chiropractic Clinic
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 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 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) _____