Family Chiropractic Center
20700 Chippendale Ave Ste 7
Farmington, MN 55024
(P) 651-460-9449 (F) 612-326-9581

ABOUT THE PATIENT

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____Gender ❑ M ❑ F

Marital Status: M D S W Partner's Name _____ Kid's Names and Ages_____

Your Employer _____ Type of Work _____

e-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Emergency Contact _____ ph # _____

How Did You Hear About Us?_____ Whom May We Thank For Referring You?_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Family Chiropractic Center to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

_____

6. How did your symptoms begin?_____
7. What makes it worse? _____
8. What makes it better?_____
9. What Doctors have you seen for this?_____
10. Type of treatment:_____
11. Results: _____

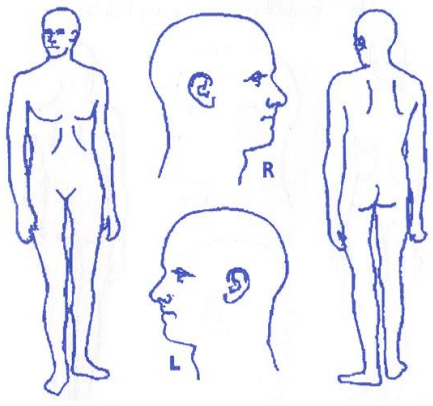
NOTES: _____

_____

_____

Are you pregnant?
❑ Yes ❑ No

Please mark All areas of concern.



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GENERAL HEALTH HISTORY

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Extremity Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Reproductive Health Issues
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. List any medications you are taking:_____
_____
2. Please list all doctors you are currently seeing: _____
_____
3. Has any doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name_____

PAST HISTORY

4. List any past auto collisions:_____ Was any care received?_____
5. List any past work injuries: _____ Was any care received?_____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____
_____
8. Please list any past hospitalizations and surgeries: _____
9. Do you have any medical devices in your body (pacemaker, metal plates, surgical screws, etc?)_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____
Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____
Is there any other family history you want us to know?_____

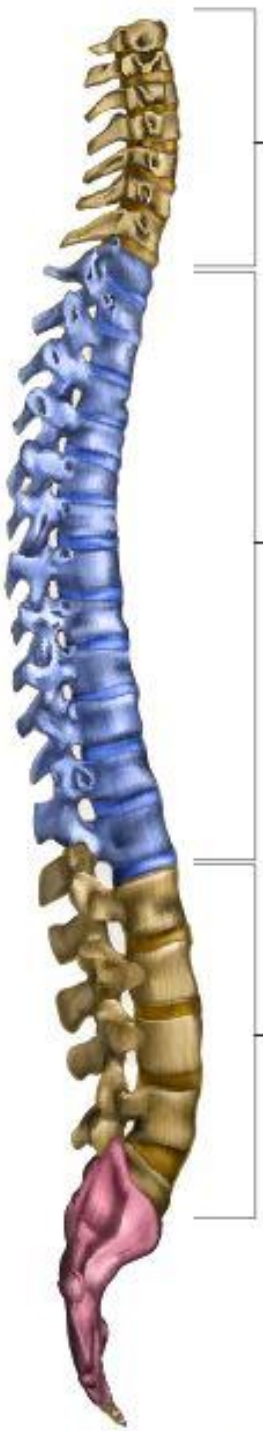
I hereby certify that the information provided is true and accurate.

Patient Signature_____ Date_____ Doctor Signature_____

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced - including both past and present



REGIONS	FUNCTIONS	SYMPTOMS	
		PAST PRESENT	PAST PRESENT
Cervical (Neck)	• Autonomic Nervous System • ENT System • Vision, balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐☐ Colic & Excessive Crying ☐☐ Ear & Sinus Infections ☐☐ Allergies & Congestion ☐☐ Immune Deficiency ☐☐ Headaches & Migraines ☐☐ Vertigo & Dizziness ☐☐ Sore Throat & Strep ☐☐ Swollen Tonsils ☐☐ Adenoids ☐☐ Vision & Hearing Issues ☐☐ Low Energy & Fatigue ☐☐ Difficulty Sleeping ☐☐ Pain, Numbness & Tingling in Arms to Hands	☐☐ Epilepsy & Seizures ☐☐ Sensory & Spectrum ☐☐ ADD / ADHD ☐☐ Focus & Memory Issues ☐☐ Anxiety & Stress ☐☐ Balance & Coordination ☐☐ Speech Issues ☐☐ TMJ / Jaw Pain ☐☐ Stiff Neck & Shoulders ☐☐ Depression ☐☐ High Blood Pressure ☐☐ Poor Metabolism & Weight control ☐☐ Acne/Skin Conditions
Thoracic (Mid-Back)	• Upper G.I. • Respiratory System • Cardiac Function • Major Digestive Center • Detox & Immunity • Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐☐ Reflux / GERD ☐☐ Chronic Colds & Cough ☐☐ Asthma ☐☐ Gallbladder Pain / Issues ☐☐ Jaundice ☐☐ Fever ☐☐ Behavior Issues ☐☐ Hyperactivity ☐☐ Chronic Fatigue ☐☐ Chronic Stress ☐☐ Liver Conditions	☐☐ Bronchitis & Pneumonia ☐☐ Functional Heart Conditions ☐☐ Pain in Sternum/Ribs ☐☐ Indigestion & Heartburn ☐☐ Stomach Pains & Ulcers ☐☐ Blood Sugar Problems ☐☐ Allergies & Eczema ☐☐ Skin Conditions / Rash ☐☐ Kidney Problems ☐☐ Gas Pain & Bloating ☐☐ Lowered Immune Reponse
Lumbar, Sacrum & Pelvis (Low Back)	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control • Reproductive Health	☐☐ Constipation ☐☐ Crohn's, Colitis & IBS ☐☐ Diarrhea ☐☐ Bed-wetting ☐☐ Bladder & Urination Issues ☐☐ Cramps & Menstrual Issues ☐☐ Cysts & Endometriosis ☐☐ Infertility ☐☐ Impotency ☐☐ Hemorrhoids	☐☐ Sciatica & Radiating Pain to legs ☐☐ Lumbopelvic / SI Joint Pain ☐☐ Hamstring Tightness ☐☐ Disc Degeneration ☐☐ Leg Weakness & Cramps ☐☐ Poor Circulation & Cold Feet ☐☐ Knee, Ankle & Foot Pain ☐☐ Weak Ankles & Arches ☐☐ Lower Back Pain ☐☐ Gluten & Casein Intolerance

FAMILY CHIROPRACTIC

Patient Name: _____ Date: _____

FAMILY
CHIROPRACTIC

INFORMED CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in the symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. The options may include, but are not limited to: self-administered care, over-the-counter pain relievers physical measures and rest, medical with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent/Guardian: _____ Signature: _____ Date: _____

FAMILY
CHIROPRACTIC

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have all take precautions that are known by this office to assure that your re cords are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

8. The patient understands and agrees to allow this office to use their name for newsletters (both mailed and emailed), birthday cards, patient testimonials, referrals, appointment reminder calls and/or mailings, use of photos, and reactivation calls and/or mailings.

The patient understands that under the Health Insurance Portability and Accountability Act (HIPAA), the patient has certain rights to privacy regarding my protected health information. The patient acknowledges that he or she has received or has been given the opportunity to receive a copy of their Notice of Privacy Practices. The patient also understands that this practice has the right to change its Notice of Privacy Practices and that the patient may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient/Guardian Name _____ Date _____

Signature _____

FAMILY
CHIROPRACTIC

Paying for care is easy! Mark which one works best for you:

_____ **Custom Care Plan**: Our care plans and simple payment arrangements have helped over 5,000 people and are sure to work great for you too! These days, insurance pays very little for natural, drugless care to get you healthy which is why we don't accept commercial insurance. Our custom care plans are broken down into monthly budget-friendly payment options and are discussed prior to starting care. We will **never** surprise you with a bill in the mail! Don't worry, you can still use your HSA or FSA dollars here!
_____ **Auto Injury:** Auto-related injuries are covered at 100% in MN - even if you were at-fault or were a passenger! You can get the care you need; we'll take care of the rest! Your insurance even covers Acupuncture, Massage, and Laser! _____ **Initial:** *By initialing here, you understand that you may be responsible for a* ***$85 no show/$45 late cancellation fee for Acupuncture and Massage appts only. We just ask for a proper notice no less than 24 hours if a cancellation is necessary****.*
_____ **Work Injury:** Work injuries are covered at 100% for up to 12 weeks of treatment. You can get the care you need; we'll take care of the rest! Your insurance even covers Acupuncture, Massage, and Laser! _____ **Initial:** *By initialing here, you understand that you may be responsible for a* ***$85 no show/$45 late cancellation fee for Acupuncture and Massage appts only. We just ask for a proper notice no less than 24 hours if a cancellation is necessary****.*
_____ **Medicare:** Regardless of your condition, Medicare pays for **active care** adjustments only. They have very strict rules and limitations. Medicare examinations are required to show you are eligible for care, but Medicare does NOT cover them ($50)! Maintenance care is not a covered service through Medicare, but we offer a discounted rate of $42/visit.

For Your Convenience*:*

We like to make things as easy as possible for our patients - including paying for care! Prior to beginning treatment, we will go over all costs anticipated with your customized plan. Feel comfortable knowing we use a secure portal to hold your credit card information and only process payments if:

- *You give us* ***authorization.***
- *Your account is* ***over 30 days past due****. At that time, we will run the card on file for the outstanding balance.*
- *If you chose to* ***discontinue care before your plan has been completed****, an account reconciliation will be performed and a payment or credit will be issued.*

Print Name _____ **Date** _____

Sign Name _____