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: _____

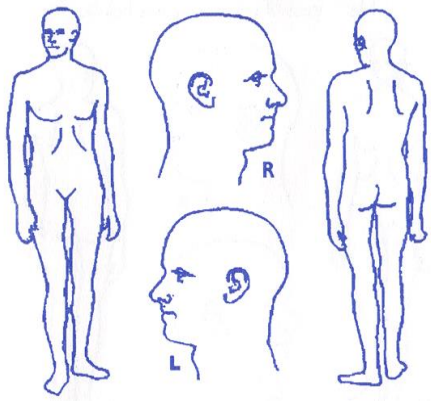
NOTES: _____

_____

_____

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

FAMILY CHIROPRACTIC

Patient Name: _____ 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 _____

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COLLISION INFORMATION

Name: _____Today's Date: _____
Where did the collision occur: Street:_____ City:_____State:_____
Date when collision occurred: _____@_____ AM or PM. Was the road: ❑ Dry ❑ Wet ❑ Snowy ❑ Icy
Where you the: ❑ Driver ❑ Front middle passenger ❑ Front right passenger ❑ Back left ❑ Back middle ❑ Back right
Describe what happened:_____
_____
_____
_____
_____

CRASH DETAILS

❑ Yes ❑ No If driving, were both hands on the wheel at impact?
❑ Yes ❑ No If passenger, did your hands brace yourself?
❑ Yes ❑ No Did you have your seat belt and shoulder strap on?
❑ Yes ❑ No Was your seat up at the time of impact?
❑ Yes ❑ No Where you wearing a bulky coat or slippery pants?
❑ Yes ❑ No Did the seat belt engage?
❑ Yes ❑ No Did the airbag engage?
❑ Yes ❑ No Did you hit the dash, steering wheel or window?
❑ Yes ❑ No Did you know you were going to be hit?
❑ Yes ❑ No Did you brace yourself with hands or feet?
❑ Yes ❑ No If driving, was your foot on the brake at impact?
❑ Yes ❑ No Was your head turned at impact?
❑ Yes ❑ No Were you leaning forward?
❑ Yes ❑ No Did your glasses fly-off at impact?
❑ Yes ❑ No Was your body turned at the moment of impact?
❑ Yes ❑ No Did you get hit into another car, tree, railing, etc?
❑ Yes ❑ No Any damage or marks on your vehicle, the vehicle that hit you, or another object that was hit?
What part of the vehicle was hit? _____

1. What make and model of vehicle were you in?_____ The other vehicle?_____
2. What kind of seat were you in? __ Bucket __ Bench __ Fabric __ Leather/Vinyl
3. Did the car have headrests? ❑ Yes ❑ No
4. Did you hit your head on the headrest? ❑ Yes ❑ No On the back window if in a small truck? ❑ Yes ❑ No
5. Was the headrest positioned: __ below __ level with __ above the center of your head
6. Did your head hurt after the collision? ❑ Yes ❑ No Did your TMJ/jaw hurt after the collision? ❑ Yes ❑ No
7. How soon after the collision did you notice any pain? _____
8. Did the crash affect: ❑ dizziness ❑ memory ❑ concentration ❑ headaches ❑ balance ❑ nightmares ❑ breathing
❑ fatigue ❑ irritability ❑ ability to read ❑ ability to listen ❑ appetite ❑ nausea ❑ vision
9. Is there anything else you want us to know?_____
_____

PROVIDERS SEEN

List **all** providers seen since injury occurred:

1. Clinic/Doctor/Hospital Name_____City_____
2. Clinic/Doctor/Hospital Name_____City_____
3. Clinic/Doctor/Hospital Name_____City_____
4. Clinic/Doctor/Hospital Name_____City_____
5. Clinic/Doctor/Hospital Name_____City_____

❑ Yes ❑ No Do you have pictures of your vehicle? Where is it being repaired?_____

❑ Yes ❑ No Do you have a copy of the police report?

Name of your Attorney if you have one:_____

Name of Your Car Insurance Co._____ Claim Number _____

Adjuster's Name _____ Adjuster's Phone #_____

Name of the Other Divers car Insurance if Applicable_____