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: ______________________

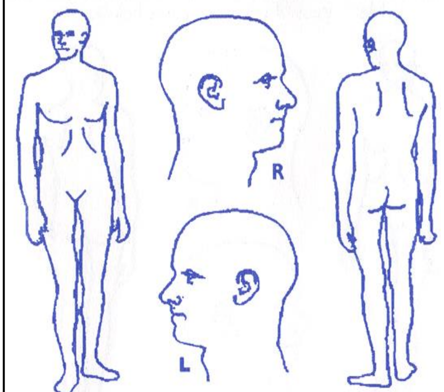
____

____

Are you pregnant?

❑ Yes ❑ No

Please mark All areas of concern.



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

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______________________

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: ______________

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 ____

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* ***$45 no show/cancellation fee for Acupuncture and Massage appts only. We just ask for a proper notice no less than 12 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* ***$45 no show/cancellation fee for Acupuncture and Massage appts only. We just ask for a proper notice no less than 12 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 ____

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

WORKER COMPENSATION INFORMATION

Patient Information
Name:______________________ Birthdate:__________ Social Security #______________
Address:____
Home Phone: (____) ______________________ E-mail:______________________
Cell Phone: (____) ______________________ Occupation:______________________

Employer
Employer Name:____
Employer Address:____
Employer Phone: (____) ______________ Injury Verified by (For Office Use Only) ______________
Contact Person:______________________ E-mail:______________________

Worker Compensation Carrier (For Office Use)
Worker Compensation Carrier:____
Carrier Address:____
Carrier Phone: (____) ______________ Coverage Verified by:______________________
Adjuster's Name:______________________ Claim Number:______________________

Injury Information
Date of Injury:__________ Time:__________ ❑ AM ❑ PM Place of Injury:______________________
Accident reported to employer? ❑ Yes ❑ No Name of Person you reported accident to:______________
Give full description of how accident happened:____
____
____
Have you lost time from work? ❑ Yes ❑ No How much?______________________
Other doctors seen for this condition: Doctor's Name______________________
Diagnosis:______________________ Were X-Rays taken? ❑ Yes ❑ No Other tests? ❑ Yes ❑ No
If yes, by whom? Please list test(s) and result(s) ______________________
____
____
Any previous Worker Compensation injuries? ❑ Yes ❑ No Date(s) of previous injuries:______________
Describe previous Worker Compensation injuries:______________________

Authorization
I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

Signature of Patient, Parent, Guardian or Personal Representative:______________________ Date:__________

Please Print Name:______________________ Relationship to Patient:______________________