Notes:_____ ROF_____ Dr._____

Fit Family Chiropractic
1835 Gateway Dr
Coon Rapids, MN 55448
Call/Text (763)710-8888

New Patient Intake

First Name_____ Middle Initial____ Last Name_____

Today's Date_____/_____/_____

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Email_____

Date of Birth _____/_____/_____ Age_____ Sex_____

How Did You Hear About Us?_____

Pronouns? He/Him She/Her They/Them Other:_____

Number of Children_____ Marital Status_____

Have You Seen A Chiropractor Before? Yes No If yes, when was the last time?_____

Employment/Student Status_____ Occupation _____

Emergency Contact Name _____ Phone Number _____

Relationship to Patient_____

If Patient is Under 18 years old

Parent/Guardian Full Name _____

Phone Number_____

Complaints	Intensity ☺1 - 10☹	Radiating pain? Where?	Constant, off/on, other?	Start date?	Cause?	Is it getting better/worse?
1.	/10					better/worse/same
2.	/10					better/worse/same
3.	/10					better/worse/same

Please circle the area of injury or discomfort on the chart

What things aggravate the pain?

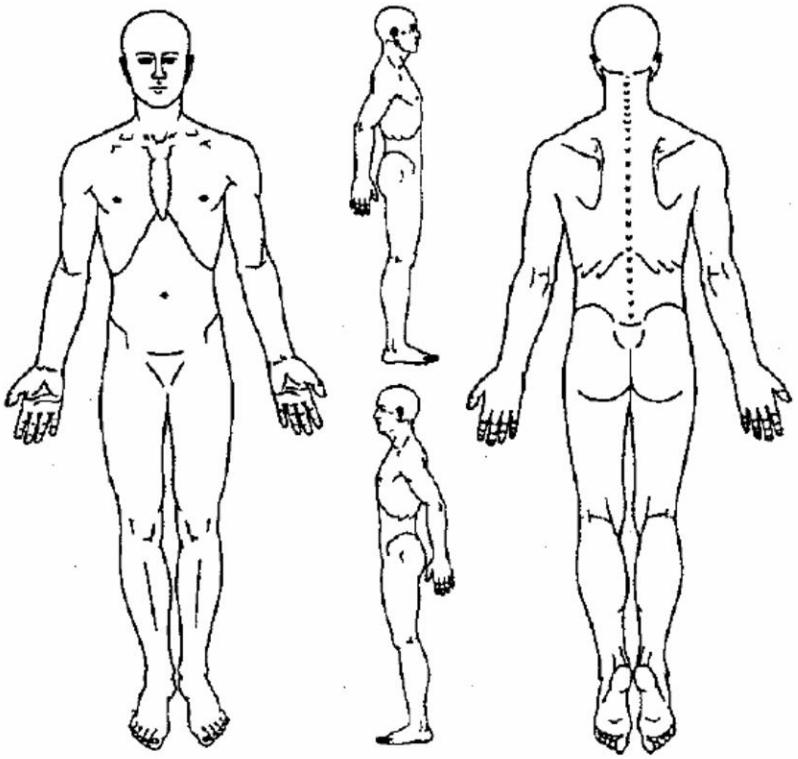
_____

What things relieve the pain if anything?

_____

Describe the pain?

- ☐ Dull
- ☐ Achy
- ☐ Sore
- ☐ Tightness
- ☐ Stiff
- ☐ Numb/Tingling
- ☐ Shooting
- ☐ Stabbing
- ☐ Burning
- ☐ Weakness
- ☐ Throbbing
- ☐ Cramping
- ☐ Sharp
- ☐ Radiating
- ☐ Other: _____



Select all tasks that have become difficult to do since the start of this/these condition(s):

- ☐ Sleeping
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Bending/Lifting
- ☐ Work
- ☐ Personal Care
- ☐ Driving/Traveling
- ☐ Using a computer
- ☐ Recreation

For Doctors Notes Only

Range of Motion Test

Cervical

- ● Flexion ___/60 Px – Stiff – Rad – Tight
- ● Extension ___/55 Px – Stiff – Rad – Tight
- ● LLF ___/40 Px – Stiff – Rad – Tight
- ● RLF ___/40 Px – Stiff – Rad – Tight
- ● L R ___/80 Px – Stiff – Rad – Tight
- ● R R ___/80 Px – Stiff – Rad – Tight

Lumbar

- ● Flexion ___/90 Px – Stiff – Rad – Tight
- ● Extension ___/30 Px – Stiff – Rad – Tight
- ● LLF ___/35 Px – Stiff – Rad – Tight
- ● RLF ___/35 Px – Stiff – Rad – Tight
- ● L R ___/30 Px – Stiff – Rad – Tight
- ● R R ___/30 Px – Stiff – Rad – Tight

MSR:

Orthos:

Personal Medical History

- ○ Arthritis
- ○ Allergies
- ○ Asthma
- ○ Alcoholism
- ○ Alzheimer's
- ○ Autoimmune Disease
- ○ Blood Pressure Issues
- ○ Bronchitis
- ○ Cancer
- ○ Chronic Fatigue Syndrome
- ○ Carpal Tunnel Syndrome
- ○ Cholesterol (elevated)
- ○ Colitis
- ○ Dental complaints
- ○ Depression/Anxiety
- ○ Diabetes
- ○ Diverticulitis
- ○ Drug addiction
- ○ Eating disorder
- ○ Epilepsy
- ○ Emphysema
- ○ Fibromyalgia
- ○ Food intolerance
- ○ Gastro-esophageal Reflux
- ○ Genetic disorder
- ○ Glaucoma
- ○ Heart Disease
- ○ Infections (Chronic)
- ○ IBS
- ○ Kidney Disease
- ○ Learning disabilities
- ○ Liver or Gall stones
- ○ Mental Illness
- ○ Migraines
- ○ Neurological Problems
- ○ Sinus Problems
- ○ Stroke
- ○ Thyroid Issues
- ○ Obesity
- ○ Osteoporosis
- ○ Pneumonia
- ○ S.T.D
- ○ S.A.D
- ○ Scoliosis
- ○ Tuberculosis
- ○ Ulcer
- ○ Urinary Tract Infections
- ○ Varicose Veins
- ○ Other:_____

Family Health History

- ○ Arthritis
- ○ Alzheimer's
- ○ Blood Pressure – high/low
- ○ Cancer- type_____
- ○ Diabetes
- ○ Fibromyalgia
- ○ Genetic Disorder
- ○ Glaucoma
- ○ Heart Disease
- ○ Infertility
- ○ Mental Illness
- ○ Migraine Headaches
- ○ Neurological Disorders
- ○ Obesity
- ○ Osteoporosis
- ○ Stroke
- ○ Suicide
- ○ Thyroid
- ○ Varicose Veins
- ○ Others:_____

Surgery:

_____
_____

Car Accident:

_____
_____

Sports/work injury:

_____
_____

Social History

- ○ Tobacco use Yes/No/Quit
  - ○ how often_____
- ○ Alcohol Yes/No
- ○ Diet/restrictions_____
  - ○ Allergies_____
- ○ Exercise
  - ○ Type_____
  - ○ Duration_____
  - ○ Frequency_____

Female:

- ○ Menstrual Irregularities
- ○ Menopause
- ○ Endometriosis
- ○ Infertility
- ○ Fibroids/ Ovarian Cysts
- ○ Premenstrual syndrome
- ○ Breast Cancer
- ○ Pelvic Inflammatory disease
- ○ Vaginal Infection
- ○ Decreased Sex Drive
- ○ Other _____
- ○ Date of last GYN exam: ___/___/_____
- ○ Mammogram: +/-
- ○ Form of Birth Control: _____

# of pregnancies: _____
# of children:_____
Vaginal/ C- Section

Are you pregnant or trying to become pregnant?
Yes/No/NA

If yes, due date: ___/___/___

Male:

- ○ Benign Prostatic Hyperplasia
- ○ Decreased Sex Drive
- ○ Infertility
- ○ Other:_____

Children:

- ○ Ear infection
- ○ Colic
- ○ Constipation/diarrhea or other digestive issues
- ○ Bed wetting/incontinence

Medications:_____
_____
_____

Informed Consent Chiropractic Treatment

The Doctor will use their hands or mechanical device to move your joints. You may feel and or hear a "click" and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, soft tissue therapies, exercise instructions, and/ or acupuncture may be recommended or also used. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are risks to treatment, including but not limited to soreness, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risk and complications, and I wish to rely upon the doctor to exercise best judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to her or him, I in my best interest. I understand that methods of treatment include, but are not limited to, electrical stimulation, x-ray, Graston, and nutritional counseling. I have been informed that Graston is a generally safe method of treatment, but that it may have some side effects, including but not limited to: bruising, tenderness or tingling near or on the soft tissue site that may last a few days. I understand that while this document describes the major risks of treatment, other side effects may occur. The nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe, although some may be toxic in large doses. I understand some supplements may be contraindicated during pregnancy. Some possible side effects of taking supplements are nausea, gas, stomachaches, vomiting, headaches, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinic staff member who is caring for me if I become pregnant.

Risks or remaining untreated:

Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and introduce chronic pain cycles. It is probable that the delay of treatment could worsen the condition and make further rehabilitation more difficult. I hereby request and consent to the performance adjustments and other chiropractic, including various modes of physical therapy and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/ or other licensed doctors of chiropractic who now or in the future work for the clinic. I have had an opportunity to discuss with the doctor of chiropractic the nature and purpose of the chiropractic adjustments and other procedure. I understand that the results are not guaranteed. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about it content, and by signing below I agree to the above- named procedures. I intend this consent to cover the entire course of treatment for my present condition and future condition(s) for which I seek treatment.

Patient or Legal Guardian

Printed Name **Signature** **Date**

For minors only:

In addition by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed Name **Signature** **Date**

Financial Policy

- **Auto Accidents**: In most cases, auto insurance pays for 100% for care related to your auto injury. You must notify your insurance company or agent that you are under care at our office and complete their "Application for Benefits" (filing a claim) immediately. If your policy has a deductible, you will be responsible for paying the amount as services are received unless other arrangements are made with our office.
- **Worker's Compensation**: In most cases, workers compensation insurance pays for 100% for care relates to your injury. You must notify your employer that you are under care at our office immediately. In general, 12 weeks of care is covered, plus 12 additional visits.
- **Medicare;** Medicare pays a portion of the manipulation charge after deductible has been met (Spinal Manipulation Only). Medicare does not pay for examinations, X-rays, physiotherapy, nutritional supplements, exercises, consultations, laboratory tests, or orthopedic exercises.

*Additional Medicare ABN form must be signed.

- **Major Medical**: Your insurance company may deny payment for the service provided to you for the following reason: that particular service is not reasonable and necessary under your insurance company's standards. For this reason, please read and sign the following statement: "I have been informed by my physician that they believe that, in my particular case, my insurance may payment for the services for the reason stated, If my insurance denies payment I agree to be personally and fully responsible for my payment."

Agreement

I have read and understand the above financial policy. I understand that, whether I have insurance coverage or not, I am personally responsible for payment of all services rendered. I hereby consent to examination, x-ray, and treatment if needed. I hereby authorize my attending doctor to release to my insurance company any information concerning my examination and/or treatment. I understand Fit Family Chiropractic/ Moe Chiro Tres PLLC may have a contract with my insurance company that allows only co-pays to be collected at the time of service. By signing this form, I am agreeing to pay my co-pays, deductibles and coinsurance at the time of service. I here assign all benefits paid as a result of claims submitted on my behalf to Moe Chiro Tres PLLC.

Patient or Legal Guardian

Printed Name **Signature** **Date**

Massage Therapy Informed Consent

This record of consent is required before the assessment or treatment and will be maintained confidentially in the client file. It may only be released to third party with prior written consent of the client

Massage Therapy includes the assessment and treatment of the soft tissues and joints of the body, using soft tissue manipulation. Treatment plans will be discussed in advance with the client and must be agreed upon prior to start

By signing below, the client agrees to the following:

- All massage treatment, information and record will be kept confidential and securely stored for use only by my massage therapist(s).
- Written consent must be given by me prior to any disclosure or sharing of my personal and clinical information with a third party.
- Privacy will be assured as I have the right to undress only to my comfort level and according to the requirements of treatment.
- The therapist will use draping as required only to expose those parts of my body that require treatment/ and or as I choose to ensure my comfort during treatment.
- During treatment, the therapist will endeavor to work such that a pain level of 6-8 is not exceeded, based on a pain scale of 1-10. Be sure to communicate with your therapist.
- If at any time during the treatment, I feel uncomfortable for any reason, I have the right to request an immediate stop to the session or request modifications to the treatment, regardless of prior given consent
- Promptness is expected for all appointments. In the event of lateness, the massage may be cut short due to other commitments of the therapist. Fees will be maintained per the schedule.
- Fees for treatment are due prior to departure on the day of the treatment. Credit/ debit cards, cash or personal checks are accepted.
- The therapist may refuse to treat any client or part of their body with just a reasonable cause
- **Cancellation of any appointment must be received at least 24 hours in advance; otherwise you will be charged a cancellation fee.**

Patient or Legal Guardian

Printed Name **Signature** **Date**

Notice of Privacy Practices Acknowledgement

We keep a record of the health care service we provide you. You may ask to see and copy your records. You can also ask to correct that record. We will not disclose your records to others unless the law authorizes or compels us to do so. You may see your records to get more information about it by contacting Moe Chiro Tres PLLC. Our Notice of Privacy Practices describes in more detail how your health information may be used, disclosed, and how you can access your information.

Additional Disclosure Policy (Check One)

☐ **No other spouse, family member or friend may have access to my health information.**

☐ **In addition to the allowable disclosures described in the "Notice of Privacy Practices" I hereby specifically authorize disclosures of my protected health care information to the person indicated below.**

Name:_____ Relationship to Patient:_____

Patient or Legal Guardian

Printed Name **Signature** **Date**

----------Stop here – Office use only ----------

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because.

- Individual refused to sign:
- Communication barriers prohibited obtaining acknowledgement
- An emergency prevented us from obtaining acknowledgement
- Other:_____