Notes _____ ROF_____ Dr. _____

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

First Name:_____ Middle Initial:___ Last Name:_____ Gender:_____

Address:_____ Cell Phone: (_____)-_____-_____

City: _____ State: _____ Zip: _____ Alt Phone: (_____)-_____-_____

Birthdate: ___ /___ /_____ Age: ____ Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partner

Email: _____ Number of Children: _____

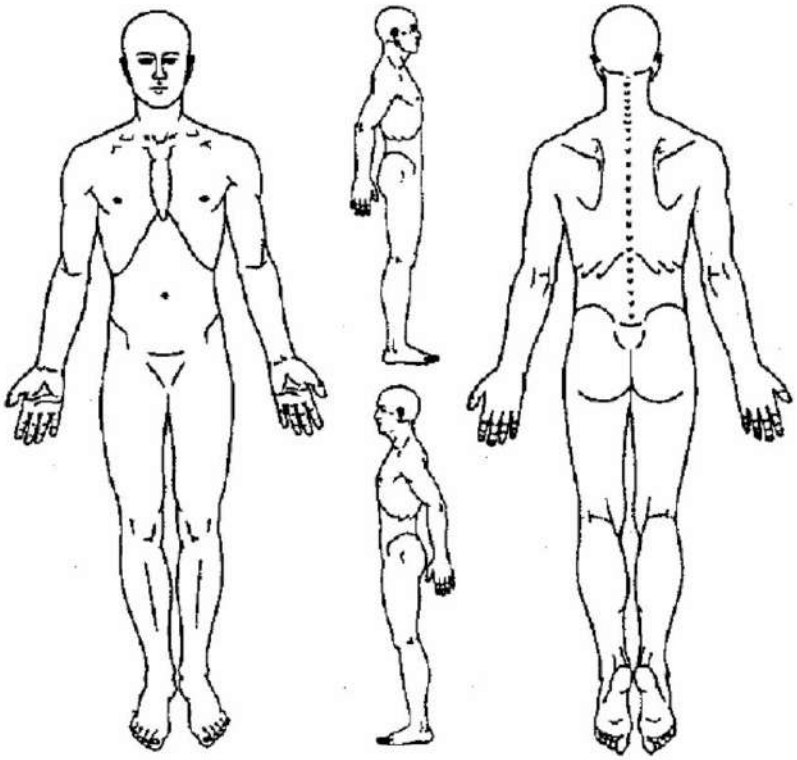
Occupation: _____How did you hear about us? _____

Emergency Contact: _____ Phone: (____)-_____-_____ Relation: _____

Complaints	Intensity ☺1 2 3 4 5 6 7 8 9 10☹	Start date?	Cause?	Is it getting better/worse?
1.	1 /10			better/worse/same
2.	1 /10			better/worse/same
3.	1 /10			better/worse/same

Pain Diagram

Please circle the area of injury or discomfort on the chart



Is this Condition related to:

- ☐ Work accident
- ☐ Sports injury
- ☐ Motor vehicle accident?
  - If yes when? _____

What things aggravate the pain?

_____

What things relieve the pain if anything?

_____

Describe the pain?

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

Medications:_____

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
- Asthma
- Alzheimer's
- Blood Pressure – high/low
- Cancer- type_____
- Depression
- Diabetes
- Drug Addiction
- Eating Disorder
- Fibromyalgia
- Food Intolerance
- Genetic Disorder
- Glaucoma
- Heart Disease
- Infertility
- Learning Disability
- Mental Illness
- Migraine Headaches
- Neurological Disorders
- Obesity
- Osteoporosis
- Stroke
- Suicide
- S.A.D
- Thyroid
- Ulcers
- Varicose Veins
- Others:_____

Social History

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

Women:

- 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:_____
Natural/ C- Section

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

If yes, due date: ___/___/___

Men:

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

Children:

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

Surgery:_____

Car Accident:_____

Sports/work injury:_____

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

Witness:

Printed Name Signature Date

Financial Policy

Regarding insurance Coverage:

- **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

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.

Patient or legal guardian:

Printed Name Signature Date

Additional Disclosure Policy

- ☐ 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 disclosure 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:_____