Bjorlie Chiropractic

Kevin Bjorlie, D.C.
1383 21st Avenue N.
Fargo, ND 58102
Office: (701) 235-8050 ▪ Fax: (701) 298-3738

ABOUT YOU

Today's Date:____/____/____ Name: _____ Preferred Name: _____

☐ Male ☐ Female Birthdate: ____/____/____ Age:_____ SS#: ____/___/_____ E-Mail Address:_____

Home Address: _____ City:_____ State:_____ Zip:_____

Home Phone #:_____-_____-_____ Cell Phone #: _____-_____-_____ Referred By:_____

Employer: _____ How Long: _____ Occupation: _____ Work Phone #: _____-_____

Work Address: _____ City:_____ State:_____ Zip:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Spouse's Name: _____

Emergency Contact? _____ Relation: _____ Home #: ____-____-_____ Work #: ____-____-_____

INSURANCE AND ACCOUNT INFO

Ins. Name: _____ Phone # ____-____-_____

Insured's Name: _____ Insured's SS#: ____/___/_____ Group # (Policy #):_____

Person Responsible for account (If not self): _____ Relation: _____

Billing Address: _____ City:_____ State:_____ Zip:_____

SS#: ____/___/_____ Phone #: ____-____-_____

Payment Method: ☐ Cash ☐ Check ☐ MasterCard ☐ Visa ☐ Discover CC#: _____ exp: ___/___
☐ I hereby Authorize assignment of my insurance rights and benefits directly to **Bjorlie Chiropractic** for services rendered.

REASON FOR VISIT

The reason for this visit is the result of (Please Circle): work sports auto accident trauma chronic

Explain what happened: _____

Describe Pain and Location: _____ When did condition begin? ____/____/____

Is this condition getting worse? ☐yes ☐no ☐constant ☐come and go Does it interfere with: ☐work ☐sleep ☐daily routine?

Have you had this condition before? ☐yes ☐no If so, please explain: _____

Have you seen a doctor for this? ☐yes ☐no If so, where? _____ Treatment given: _____

HEALTH HISTORY

Are you taking any medications? ☐ yes ☐ no If so, please list: _____

Have you ever had any of the following diseases or medical conditions?

Y N Heart attack / Stroke	Y N Heart Surg./ Pacemaker	Y N Heart Murmur	Y N Heart Defect
Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N HIV + / Aids
Y N Shingles	Y N Cancer	Y N Neck Pain	Y N Emphysema
Y N Anemia	Y N High/Low Blood Pressure	Y N Psychiatric Problem	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers / Colitis	Y N Fainting
Y N Seizures / Epilepsy	Y N Sinus Problems	Y N Asthma	Y N Diabetes
Y N Tuberculosis	Y N Difficulty Breathing	Y N Low Back Pain	Y N Arthritis

Please list any other medical conditions you have had: _____

Please list any allergies: _____

Please list surgeries with dates: _____

List any past serious accidents / injuries with dates: _____

Do you smoke? ☐ yes ☐ no How much? _____ How long? _____

Are you wearing: ☐ heel/sole lifts ☐ orthotics ☐ arch supports? Age of mattress? _____ Is it comfortable? _____

Height:_____ Weight: _____ Any recent change in weight? ☐ yes ☐ no If so, how much? _____

FOR WOMEN: Taking birth control: ☐ yes ☐ no Pregnant? ☐ yes ☐ no If so, how long? _____Nursing? ☐yes ☐no

WHERE DOES IT HURT?

Please read carefully.

Mark the areas on your body where you feel your pain using the symbols as shown below. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrows as far as the pain travels.

Ache >>>>
>>>>

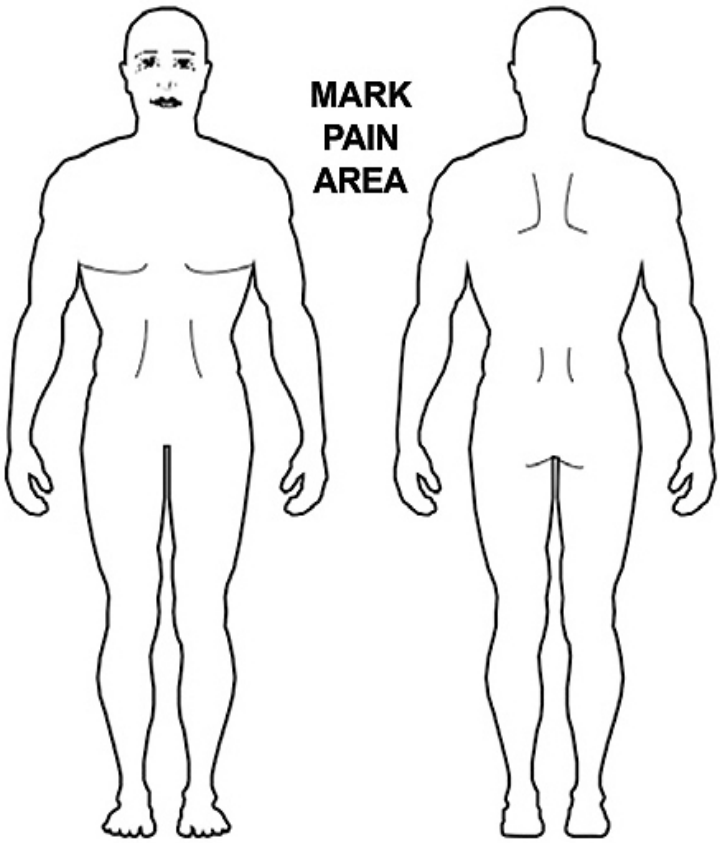
Numbness ----

Stabbing ////
////

Throbbing ~~~~
~~~~

Pins and Needles oooo
oooo

Burning xxxx
xxxx



TYPE OF CARE

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual, understanding between provider and patient.
- I hereby assign payment directly to the facility for services covered by insurance. I understand that I am personally responsible for all charges.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made in advance. If account is not paid within 90 days from the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
- I hereby acknowledge Bjorlie Chiropractic has provided me with a copy of their Privacy Notice.
- I authorize Bjorlie Chiropractic to contact me, either by phone or by mail to provide a reminder of an appointment, to confirm any demographic or insurance information, or information about new services Bjorlie Chiropractic will be offering.

Signature: _____ Date: _____/_____/_____
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