Waconia Family Chiropractic

PATIENT INFORMATION

Last Name:_____ First Name:_____MI:_____

Address:_____Apt/Unit:_____

City: _____State:_____Zip Code:_____

Home Phone:_____Work Phone:_____Cell/Other:_____

Email Address:_____Would you like to receive reminder emails?_____

Birthdate:_____Age:_____Gender: ○Male ○Female

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

Occupation:_____Employer:_____

How were you referred to Waconia Family Chiropractic? □ Family Member □ Friend □ Doctor □ Other_____

Please give us the name of the family member, friend or doctor that referred you:_____

Emergency Contact:_____Phone Number:_____Relationship to the Patient:_____

Only accepting MEDICARE, AUTO and WORK COMP Insurance.

Insurance Company:_____ Policy Number:_____Group Number:_____
Policy Holder's Name:_____ Policy Holder's Birthdate:_____
Policy Holder's SS#:(AUTO CASES ONLY)_____ Policy Holder's Employer:_____
Policy Holder's Relationship to the Patient: □ Self □ Spouse □ Parent/Guardian □ Other_____

What are your current complaints?_____

When did your problem begin?_____

How did this problem begin?_____

Is your current injury/condition related to an auto/work accident? □ Yes □ No If yes, what is the date of the accident?_____

Please describe your current pain.

□ Sharp □ Dull Ache □ Numb □ Shooting
□ Burning □ Tingling □ Other_____

Since your problem began, is the pain…

□ Increasing □ Decreasing □ Not Changing

How frequent is your pain?

□ Constantly □ Frequently □ Occasionally □ Intermittently

What makes your problem better?_____

_____

What makes your problem worse?_____

_____

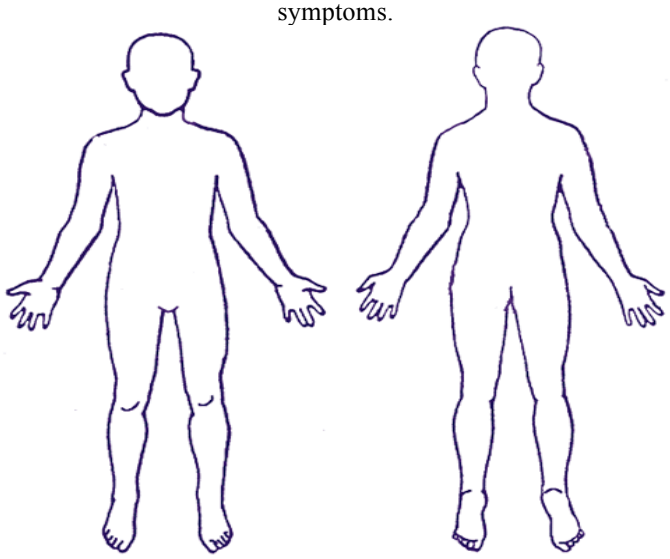
Other health care providers consulted for this condition.

_____

Date of last physical examination_____

Women: Are you or is there a possibility that you may be pregnant?_____ If yes, what is the due date?_____

Please mark the location where you have the pain or other symptoms.



Rate the severity of your pain

None Unbearable

0 1 2 3 4 5 6 7 8 9 10

Please turn the page over.

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Please indicate if you have had or presently have any of the following conditions (more common conditions – have you had recently?):

Cardiovascular

___Fainting ___Heart Disease ___High/Low Blood Pressure ___Irregular Heartbeat ___Phlebitis
___Poor Circulation ___Swelling of Hands/Feet ___Swelling of Legs ___Other_____

Ears/Nose/Throat

___Dizziness ___Hearing Loss ___Sinus Infection ___Nose Bleed ___Sore Throat
___Jaw Clicks ___Bleeding Gums ___Difficulty Swallowing ___Other_____

Gastrointestinal

___Nausea/Vomiting ___Liver Problems ___Constipation ___Diarrhea ___Ulcers
___Black/Bloody Stools ___Gallbladder Problems ___Bowel Problems ___Other_____

Musculoskeletal

___Osteporosos ___Arthritis ___Joint Stiffness
___Muscle Weakness ___Gout
___Broken Bones ___Joints Replaced
___Other_____

Respiratory

___Asthma ___Bronchitis ___Cold/Flu
___Cough/Wheezing ___Emphysema
___Difficulty Breathing ___Pneumonia ___Shortness of Breath
___Other_____

Eyes

___Glaucoma ___Double Vision ___Blurred Vision
___Color Blindness ___Cataracts
___Glasses ___Eye Pain ___Poor Vision

Genitourinary

___Kidney Disease ___Burning Urination ___Frequent Urination
___Blood in Urine
___Kidney Stone ___Lower Side Pain
___Other_____

Neurological

___Stroke ___Seizures ___Severe Headaches
___Numbness ___Head Injury
___Pinched Nerves ___Carpal Tunnel ___Brain Aneurysm
___Other_____

Hematologic/Lymphatic

___Hepatitis ___Blood Clots ___Easy Bleeding ___Easy Bruising ___Cancer
___Fever ___Chills ___Sweats
___Other_____

Endocrine/Constitutional

___Diabetes ___Thyroid Disorder ___Menstrual Problems
___Other_____
___Weight Gain ___Weight Loss ___Difficulty Sleeping
___Other_____

Surgeries (Type and Date)_____

_____

_____

_____

Serious illness or injury (date):_____

_____

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Allergies:_____

_____

Medications taken within the last two months (include over the counter and vitamins):_____

_____

_____

Occupational Stresses:_____

_____

Habits: Alcohol (use/week) _____ Tobacco (use/week) _____ Drugs (type, use/week) _____

Are there any other issues concerning your health that you would like the doctor to be aware of?_____

_____

_____

Have you had any other significant traumas? (Auto accidents, falls, etc…date):_____

_____

_____

Patient Name (Please Print)_____

_____

Name of Person Completing this form_____ **Relationship to the Patient**_____

Signature of patient or person completing this form_____

Date:_____

_____

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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 will begin any health care treatments we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic 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 taken all precautions that are known by this office to assure that your records 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. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. 8. I understand that upon entering this clinic, my name will be signed on a sign-in sheet that will remain in the reception area of the clinic. I also realize that any person entering this office may read my name on the sign-in sheet as a patient.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

PRINT Patient Name

Patient or Guardian Signature Date

9384 Oak Ave, Ste A Waconia, MN 55387 952-442-3220

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DOCTOR-PATIENT RELATIONSHIP AND INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy, and Medicine, and for the patient to understand what to expect from chiropractic care. It is the chiropractic premise that proper spinal alignment allows normal nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. In this way, chiropractic health care seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of chiropractic procedures often depends on environment, underlying causes, and the physical and spinal conditions of each individual patient. It is important that the patient understands what to expect from your chiropractic care. Due to the complexities of nature, and the many variables (both known and unknown) that can affect a patient's response, no doctor can promise specific results. The Doctor of Chiropractic provides a specialized, unique, non-duplicating health service. The Doctor of Chiropractic is licensed in a special area of practice and is available to work with other types of providers in your health care regime.

ANALYSIS

Your doctor will conduct a clinical analysis for the express purpose of determining whether there is evidence that your situation may be the result of a vertebral subluxation and that you might respond satisfactorily to chiropractic care. If such is found, chiropractic care will be recommended in an attempt to restore spinal integrity.

RESULTS

The purpose of chiropractic care is to promote natural health through the reduction of the vertebral subluxation. Since there are so many variables, it is difficult to predict the time schedule or the efficacy of the chiropractic adjustment on any given patient. Sometimes the response is phenomenal, however, in most cases; there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same type of care and actual response is not predictable. Many medical failures have found significant benefit through chiropractic care. In turn, many conditions, which do not respond to chiropractic care, may be helped through medical treatment. Chiropractic and medicine may never be so exact as to provide definite answers to all problems; however, both have made great strides in patient care.

DIAGNOSIS

Although Doctors of Chiropractic are experts in the analysis of the structural alignment of the human spine, and its effects on the nervous system, they are not internal medical specialists. Every patient should be mindful of his/her own symptoms and should secure other opinions should he/she have any concerns as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

By signing below, the patient gives the doctor permission and authority to care for him/her in accordance with recognized and acceptable chiropractic analytical and corrective procedures. The chiropractic adjustment is usually beneficial and seldom causes any adverse reactions. In rare cases, undetected physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give an adjustment if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through other health care procedures whether he/she is suffering from pathological conditions (latent or otherwise), illnesses, injuries, or deformities which would otherwise not come to the attention of the doctor.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing this statement of understanding and consent for care.

I have read and understand the foregoing explanation of chiropractic care given to me. I hereby give my consent for the doctor to render chiropractic care to me.

PRINT Patient Name:_____

Patient or Guardian Signature:_____ Date:_____

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