NEW PATIENT FORMS

ABOUT THE PATIENT

Last Name

First Name (Legal)

Preferred Name (Nickname)

Birthday

Street Address

City

State/Province

Zip Code

Cell Phone

Email

Gender

◯ Male ◯ Female

Marital Status

◯ Married ◯ Single

Who can we thank for referring you?

About the Spouse

First Name

Last Name

Employer Information

Employer

Type of Work

Reason for this Visit

Complaint #1

How long has this been an issue

Is it

☐ Dull ☐ Sharp ☐ Ache ☐ Numb
☐ Stabbing ☐ Constant ☐ Getting Worse ☐ Staying the Same

Complaint #2

How long has this been an issue?

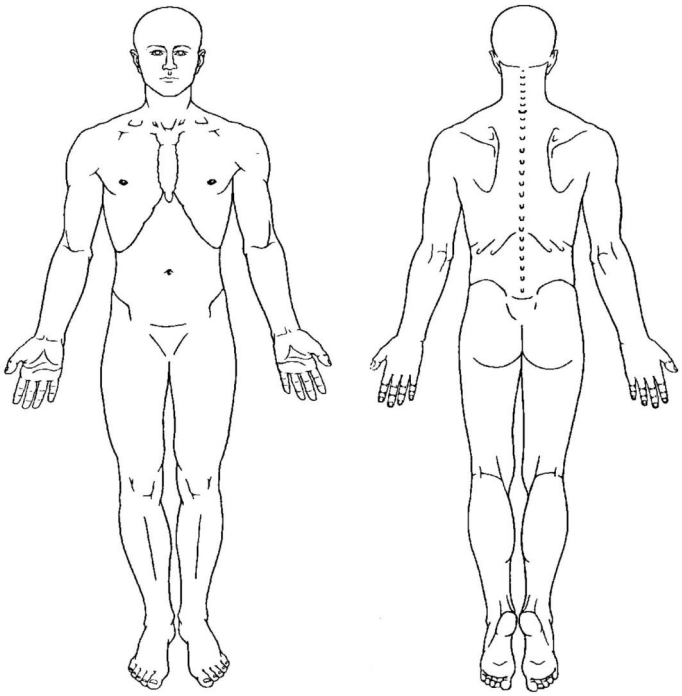
Is it

- ☐ Dull
- ☐ Sharp
- ☐ Ache
- ☐ Numb
- ☐ Stabbing
- ☐ Constant
- ☐ Getting Worse
- ☐ Staying the Same

Does your condition affect

- ☐ Sleep
- ☐ Work
- ☐ Daily Routine
- ☐ Exercise
- ☐ Driving

Mark your Pain Point(s)



What makes it better?

What makes it worse?

Doctor's Name (s)

Type of Treatment

Results

ANYTHING ELSE THE DR SHOULD KNOW ABOUT YOUR CONDITION

Are you pregnant?

- ◯ Yes
- ◯ No

If yes, when is your due date?

Experience with Chiropractic

Who referred you to this office?

Have you been adjusted by a chiropractor before?

◯ Yes ◯ No

Reason for those visits?

Doctor's Name

Approximate date of last visit?

General Health History

Check any CURRENT Health Conditions:

- ☐ Headaches
- ☐ Medication Side Effects
- ☐ Trouble Walking
- ☐ Ringing in Ears
- ☐ Thyroid Problems
- ☐ Urinary Problems
- ☐ Fibromyalgia
- ☐ Depression
- ☐ High Cholesterol
- ☐ Tension
- ☐ Migraines
- ☐ Diabetes
- ☐ Leg/Foot Numbness
- ☐ Ear Problems
- ☐ Liver Disease
- ☐ Easy Bruising
- ☐ Blood Thinner Use
- ☐ Alcohol Use
- ☐ TMJ
- ☐ Chest Pains
- ☐ Shortness of Breath
- ☐ Hands or Feet Cold
- ☐ Fainting
- ☐ Sleeping Problems
- ☐ Kidney Problems
- ☐ Tobacco Use
- ☐ HIV Positive
- ☐ High/Low Blood Pressure
- ☐ Digestive Problems
- ☐ Heart Pacemaker
- ☐ Allergies/Asthma
- ☐ Muscle Aches
- ☐ Gall Bladder Trouble
- ☐ Vision Problems
- ☐ Light Bothers Eyes
- ☐ Dental Problems
- ☐ Cancer
- ☐ Stroke History
- ☐ Pain All Over
- ☐ Heart Problems

Check any PAST Health Conditions:

- ☐ Headaches
- ☐ Medication Side Effects
- ☐ Trouble Walking
- ☐ Ringing in Ears
- ☐ Thyroid Problems
- ☐ Urinary Problems
- ☐ Fibromyalgia
- ☐ Depression
- ☐ High Cholesterol
- ☐ Tension
- ☐ Migraines
- ☐ Diabetes
- ☐ Leg/Foot Numbness
- ☐ Ear Problems
- ☐ Liver Disease
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- ☐ Gall Bladder Trouble
- ☐ Vision Problems
- ☐ Light Bothers Eyes
- ☐ Dental Problems
- ☐ Cancer
- ☐ Stroke History
- ☐ Pain All Over
- ☐ Heart Problems

List any medications you are taking

List any supplements you are taking

Past History

List dates of any past auto collisions

Was any care received?

List dates of any past work injuries

Was any care received?

List any past sport, recreational, or home injuries

Please describe any past conditions and treatments received

Please list any past hospitalizations and surgeries

Family History

Father's side

- [ ] Heart Disease
- [ ] Cancer
- [ ] Diabetes
- [ ] Heavy Medication use
- [ ] Arthritis
- [ ] Spine Surgery

Mother's side

- [ ] Heart Disease
- [ ] Cancer
- [ ] Diabetes
- [ ] Heavy Medication use
- [ ] Arthritis
- [ ] Spine Surgery

Office Policy and Privacy Policy

SPINAL CHECK-UP:

- We recommend everyone have their spine checked early for spinal problems. Prevention is the best medicine.
- Children especially, to see if their spine is developing abnormally? A spinal check—up is easy and fun for kids.

AGREEMENTS FOR TOP RESULTS:

- Remember it takes time and effort to improve your health. *No time + No effort = No results*
- Please keep your appointments and make-up any missed or rescheduled visits within a day whenever possible.
- Please call if you are going to be late or need to reschedule.
- Feel welcome to refer your family and friends in for care. We are here to help them too.
- If you're paid ahead, understand you will get any unused money back if care ends early.
- I agree to allow my/family name, photo, video, or testimonial to be used during the normal course of business.
- I understand that adjusting time is for adjustments and I can always talk to the Doctor by special appointment or phone call. He is here to help you any way he can. We want you to do great!

OFFICE VISITS MAY INCLUDE:

- **Specific Chiropractic Adjustments** to promote mobility, stimulate tissue, enhance alignment. This is when the Doctor works directly on your neck or back, sometimes making a popping sound. $50 to $70
- **Extremity Adjustments**to promote mobility, stimulate tissue, enhance alignment of extremity joints. $35
- **Intersegmental / Mechanical traction**to tense / relax soft tissues, aid healing and mobility. This is the black table with the rollers that effectively extend, stretch, and traction the spine. $40
- **Manual Therapy** to modulate pain, increase flexibility, reduce swelling, mobilize soft tissues. This is hands-on work to your spine or other joints performed by the doctor. $35
- **Heat Therapy for subacute and chronic conditions with the digital heat pack used on the area of concern.** $50
- **Spinal Decompression for relieving pressure on degenerative joints, bulging and herniated discs. $65**
- **Supplements/ Nutritional Products** if needed and as priced.

Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

· You may request restrictions on your disclosures.

· You may inspect and receive copies of your records within 30 days with a request.

· You may request to view changes to your records.

· In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

· Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.

· Obtain payment from third party payers.

· Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Signature

Date Signed

Printed Name

Email

COLLISION INFORMATION

Health Connection Family Chiropractic 5101 Thimsen Ave #106 Minnetonka, MN 55345

Name: _____Today's Date: _____

Where did the collision occur: Street:_____ City:_____State:_____

Date when collision occurred: _____ AM or PM. Was the road: ❑ Dry ❑ Wet ❑ Snowy ❑ Icy

Where you the: ❑ Driver ❑ Front middle passenger ❑ Front right passenger ❑ Back left ❑ Back middle ❑ Back right

Describe what happened:_____

_____

_____

_____

_____

CRASH DETAILS

❑ Yes ❑ No If driving, were both hands on the wheel at impact?

❑ Yes ❑ No If passenger, did your hands brace yourself?

❑ Yes ❑ No Did you have your seat belt and shoulder strap on?

❑ Yes ❑ No Was your seat up at the time of impact?

❑ Yes ❑ No Where you wearing a bulky coat or slippery pants?

❑ Yes ❑ No Did the seat belt engage?

❑ Yes ❑ No Did the airbag engage?

❑ Yes ❑ No Did you hit the dash, steering wheel or window?

❑ Yes ❑ No Did you know you were going to be hit?

❑ Yes ❑ No Did you brace yourself with hands or feet?

❑ Yes ❑ No If driving, was your foot on the brake at impact?

❑ Yes ❑ No Was your head turned at impact?

❑ Yes ❑ No Were you leaning forward?

❑ Yes ❑ No Did your glasses fly-off at impact?

❑ Yes ❑ No Was your body turned at the moment of impact?

❑ Yes ❑ No Did you get hit into another car, tree, railing, etc?

❑ Yes ❑ No Any damage or marks on your vehicle, the vehicle that hit you, or another object that was hit?

What part of the vehicle was hit? _____

1. What make and model of vehicle were you in?_____ The other vehicle?_____
2. What kind of seat were you in? __ Bucket __ Bench __ Fabric __ Leather/Vinyl
3. Did the car have headrests? ❑ Yes ❑ No
4. Did you hit your head on the headrest? ❑ Yes ❑ No On the back window if in a small truck? ❑ Yes ❑ No
5. Was the headrest positioned: __ below __ level with __ above the center of your head
6. Did your head hurt after the collision? ❑ Yes ❑ No Did your TMJ/jaw hurt after the collision? ❑ Yes ❑ No
7. How soon after the collision did you notice any pain? _____
8. Did the crash affect: ❑ dizziness ❑ memory ❑ concentration ❑ headaches ❑ balance ❑ nightmares ❑ breathing ❑ fatigue ❑ irritability ❑ ability to read ❑ ability to listen ❑ appetite ❑ nausea ❑ vision
9. Is there anything else you want us to know?_____

_____

PROVIDERS SEEN

List **all** providers seen since injury occurred:

1. Clinic/Doctor/Hospital Name_____City_____
2. Clinic/Doctor/Hospital Name_____City_____
3. Clinic/Doctor/Hospital Name_____City_____
4. Clinic/Doctor/Hospital Name_____City_____
5. Clinic/Doctor/Hospital Name_____City_____

❑ Yes ❑ No Do you have pictures of your vehicle? Where is it being repaired?_____

❑ Yes ❑ No Do you have a copy of the police report?

Name of your Attorney if you have one:_____

Name of Your Car Insurance Co._____ Your Health Ins. Co. _____

Name of the Other Divers car Insurance if Applicable_____