Chaska Lakes Chiropractic

Last Name: _____ First Name: _____ DOB: ____/____/____

Sex: Male or Female SSN: _____-_____-_____ Marital Status: M S W D

Home Address: _____#:_____

City: _____ State: _____ Zip Code: _____ Home Ph: _____

Cell Ph: _____ Email Address:_____

Emergency Contact:_____Relation & Phone:_____

Name of Employer: _____ Occupation: _____

How were you referred to our clinic? _____

Insurance Company: _____ Secondary Insurance Company:_____

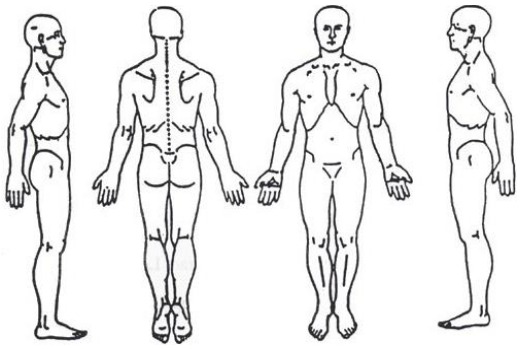
AUTHORIZATION AND RELEASE:

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient Signature: _____ Date: _____

If applicable, Guardian Signature: _____ Date_____

1. Is today's problem caused by: □ Auto Accident □ Worker's Compensation (indicate below your pain/symptoms)



2. How often do you experience your symptoms?

□ Constantly (76-100% of the time)

□ Frequently (51-75% of the time)

□ Occasionally (26-50% of the time)

□ Intermittently (1-25% of the time)

3. How would you describe the type of pain?

□ Sharp	□ Numb	□ Dull	□ Tingly
□ Diffuse	□ Sharp with motion	□ Achy	□ Shooting with motion
□ Burning	□ Stabbing with motion	□ Shooting	□ Electric like with motion
□ Stiff	□ Other:_____		

4. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

5. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

6. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

7. Who else have you seen for your problem?

□ Chiropractor	□ Neurologist	□ Primary Care Physician
□ ER physician	□ Orthopedist	□ Other:_____
□ Massage Therapist	□ Physical Therapist	

8. How long have you had this problem and how did it begin: _____

9. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

10.What aggravates your problem?

_____

11. What concerns you the most about your problem/what does it prevent you from doing?

_____

12. What is your: Height_____ Weight _____ Date of Birth _____ Occupation _____

13. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

14.What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

15. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis	□ Diabetes	□ Lupus
□ Heart Problems	□ Cancer	□ ALS

16. Please place a check in the appropriate column if you have had or currently have any conditions below:

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	(**For Females Only)**	
□	□ Neck Pain	□	□ Heart Attack	□	□ Birth Control
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Hormonal Replacement
□	□ Mid Back Pain	□	□ Stroke	□	□ Pregnancy
□	□ Low Back Pain	□	□ Dizziness		
□	□ Shoulder Pain	□	□ Kidney Stones		
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders		
□	□ Wrist Pain	□	□ Bladder Infection		
□	□ Hand Pain	□	□ Painful Urination		
□	□ Hip Pain	□	□ Loss of Bladder Control		
□	□ Upper Leg Pain	□	□ Visual Disturbances		
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite		
□	□ Jaw Pain	□	□ Abdominal Pain		
□	□ Joint Pain/Stiffness	□	□ Ulcer		
□	□ Arthritis	□	□ Muscular Incoordination		
□	□ Rheumatoid Arthritis	□	□ General Fatigue		
□	□ Cancer/Tumor	□	□ Smoking/Tobacco Use		
□	□ Dermatitis/Eczema/Rash	□	□ Frequent Urination		
□	□ Asthma	□	□ Excessive Thirst		
□	□ Chronic Sinusitis	□	□ Diabetes		
□	□ Depression	□	□ Systemic Lupus		
□	□ HIV/AIDS	□	□ Epilepsy		
□	□ Allergies	□	□ Drug/Alcohol Dependence		

17. List all prescriptions AND over-the-counter medications you are currently taking:

_____

18. List all surgical procedures you have had:

_____

19. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

20. What activities do you do outside of work?

_____

21. Have you had significant past physical trauma? □ No □ Yes **If yes, what:** _____

22. Anything else pertinent to your visit today?_____

Informed Consent

By signing this form, I consent and authorize my medical health care professional to assess and treat me. I understand that my provider is available to explain the purpose of treatment and that I have the right to refuse recommended treatment. I consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time due to the type of treatment(s) rendered and the portions of my body that need to be examined. I understand that Copays and Cash Rates are due at the time of service. In the event an account shall ever become delinquent, there will be an additional fee for collections and if there is a returned check, a fee for the insufficient funds from our banking institution. We offer payment plans with prior credit approval and signed agreements.

Print Name: _____ Signature: _____ Date: _____

Parent/Guardian Name & Signature: _____

_____ ***(←patient initials here) I acknowledge that I have been offered a copy of the HIPPA policy for Chaska Lakes Chiropractic. If I wish to have one for myself, I am able to request a copy from the Office Manager.***

Please read, mark and initial which **one** is you:

□ **No Insurance**: Easy! Our Care Plans and simple payment arrangements have helped hundreds of people, and will work great for you too!

Initial_____

□ **Health Insurance:**

•These days, insurance pays very little if anything for natural care to get you healthy. So we make it easy!

• We will verify any benefits you may have and send your claims in to your insurance for you.

• You are responsible for any deductible, co-insurance, co-pays and unpaid visits.

•Of course you can use your HSA, HRA and Flex dollars here!

•For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.

Initial_____

□ **Auto Injury:**

•Auto related injuries are typically covered 100% in Minnesota. Even if you were at fault or were a passenger. You can get the care you need and it costs you nothing. Great for you!

•All we need is your claim number, date of injury, insurance, and attorney info.

Initial_____

□ **Work Injury:**

•Work injuries are covered 100% for up to 12 weeks of care.

•All we need is your claim number and Work Comp insurance info.

Initial_____

□ **Medicare:**

Regardless of your condition, Medicare pays for up to a maximum of 12 weeks of care. They have very strict rules and limitations.

•After this you will receive a significant Medicare discount. We simply need a copy of your Medicare card.

•Medicare supplements normally don't pay anything.

Initial_____