Care Chiropractic Body Wellness Center
3390 Coachman Road, Suite 214, Eagan, MN 55121
Care at the Metropolitan, 7300 France Avenue S., Suite 300, Edina, MN 55435

PERSONAL INFORMATION

Name: _____ Like to be called: _____ Age: _____

Address: _____ / _____ / _____
Street *City* *State* *Zip Code*

Email Address:_____

Home#: _____ Work #: _____ Cell #: _____

Birth Date: _____ Gender: Female/Male (please circle)

Occupation: _____ Employer: _____

Marital Status: _____ Spouse Name: _____

Emergency Contact: _____ Phone: _____

How did you hear about our clinic? _____

GOALS FOR MY CARE

People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort. Others are interested in having the cause of the problem as well as symptoms corrected and relieved. Please check the type of care you desire so that we may be guided by your wishes whenever possible.

- ❑ **Relief care -** Symptomatic relief of pain or discomfort only.
- ❑ **Corrective care** – correcting and relieving the cause of the problem as well as the symptomatic relief.
- ❑ **Comprehensive care** – Bringing whatever is malfunctioning in the body to the highest state of health possible through chiropractic care.
- ❑ **I would like the Doctor to select the type of care appropriate for my conditions.**

AUTHORIZATION FOR CARE

I hereby authorize the Care Chiropractic Body & Wellness Center to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. Care Chiropractic will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that this office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt.

_____ _____
Signature **Date**

_____ _____
Guardian Signature Authorizing Care to Minor Child **Date**

Who should receive bills for payment on your account?

❑ **Self** ❑ **Spouse** ❑ **Parent** ❑ **Worker's Comp** ❑ **Auto Insurance** ❑ **Medicare** ❑ **Health Insurance**

CARE CHIROPRACTIC BODY WELLNESS CENTER

Preliminary Patient History

PATIENT NAME: _____ AGE: _____ DATE: _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____
When did this condition begin? _____
Is the purpose of this appointment related to:
□ Job □ Sports □ Auto □ Fall □ Home Injury □ Chronic Discomfort
If job related, have you notified your employer? □ YES □ NO
Has this condition
□ gotten worse □ stayed constant □ come and goes
Does this condition interfere with:
□ Work □ Sleep □ Daily routine □ Other activities
Please explain _____
Has this condition occurred before? □ YES □ NO
Please explain _____
Have you seen other doctors for this condition? □ YES □ NO
Doctor's Name(s) _____
Type of treatment _____
Results _____

HEALTH HABITS

Do you smoke? □ YES □ NO
Do you drink alcohol? □ YES □ NO
Do you drink coffee, tea or soda? □ YES □ NO
Do you exercise regularly? □ YES □ NO
Do you wear:
□ Heel lifts □ Sole lifts □ Inner soles □ arch supports

MEDICATIONS you are currently taking

□ Antibiotics □ Aspirin □ Anti-Inflammatory
□ Birth Control □ Blood Pressure □ Cold Remedies
□ Diuretics □ Insulin □ Muscle Relaxers
□ Pain Killers □ Steroids □ Tranquilizers
□ Other
Vitamins & Supplements currently taking: _____
_____
Previous chiropractic care? □ YES □ NO
If yes, who? _____ Date: _____

HEALTH CONDITIONS

Please check each of the diseases or conditions that the patient has now or has had in the past. While they may seem unrelated to the purpose of this appointment, they can affect the overall diagnosis and care plan.

❑ Alcoholism	❑ Chicken Pox	❑ Glaucoma	❑ HIV+/AIDS	❑ Neuralgia	❑ Tuberculosis
❑ Allergies	❑ Diabetes	❑ Goiter	❑ Measles	❑ Polio	❑ Ulcers
❑ Anemia	❑ Drug Dependency	❑ Gout	❑ Mental Disorders	❑ Rheumatic Fever	
❑ Appendicitis	❑ Eczema	❑ Headache	❑ Multiple Sclerosis	❑ Rubella	
❑ Arthritis	❑ Emphysema	❑ Heart Disease	❑ Mumps	❑ Stress	
❑ Cancer	❑ Epilepsy	❑ Hepatitis	❑ Miscarriage	❑ Stroke	

Other conditions not mentioned above: _____

Have you ever:			**Describe Briefly:**
Been in an automobile collision?	❑ Yes	❑ No	_____
Experienced a loss of consciousness?	❑ Yes	❑ No	_____
Used a cane, crutch, or other support?	❑ Yes	❑ No	_____
Been treated for a spine or nerve disorder?	❑ Yes	❑ No	_____
Had a fractured bone?	❑ Yes	❑ No	_____
Been hospitalized other then for surgery?	❑ Yes	❑ No	_____
Undergone surgery?	❑ Yes	❑ No	_____
Had any other injury?	❑ Yes	❑ No	_____

EXAM HISTORY: check box that most accurately describes times since last exam

Spinal Exam	□ <6 mos.	□ 6-18 mos.	□ >18mos.	□ None
Physical Exam	□ <6 mos.	□ 6-18 mos.	□ >18 mos.	□ None
Lab Work	□ <6 mos.	□ 6-18 mos.	□ >18 mos.	□ None
X-rays	□ <6 mos.	□ -18 mos.	□ >18 mos.	□ None

Please mark the appropriate box for any of the following symptoms you are now experiencing or have experienced in the past.

O-Occasional F-Frequent Constant

O	F	C	GENERAL
			Convulsions
			Dizziness
			Fainting
			Fatigue
			Fever
			Headache
			Loss of Sleep
			Numbness
			Weight Gain/Loss

O	F	C	MUSCULO-SKELETAL
			Low back pain
			Mid back pain
			Upper back pain
			Bursitis
			Neck Pain/Stiffness
			Pain Between Shoulders
			Joint Pain/Stiffness

O	F	C	SKIN
			Bruise Easily
			Dryness
			Eruptions/Rashes
			Varicose Veins

O	F	C	GENITOURINARY
			Bedwetting
			Bladder Problems
			Discolored Urine
			Kidney Problems
			Painful/Excessive Urination

O	F	C	MALES ONLY
			Breast Pain/Lumps
			Prostate Problems
			Sexual Dysfunction

O	F	C	PAIN/NUMBNESS OF
			Shoulder
			Arm
			Elbow
			Wrist
			Hand
			Hip
			Leg
			Knee
			Ankle
			Foot
			Sciatic Pain
			Swollen Joints

O	F	C	NERVOUS SYSTEM
			Cold/Tingling
			Extremities
			Depression
			Forgetfulness/Confusion
			Nervousness/Anxiety
			Paralysis

O	F	C	GASTROINTESTINAL
			Abdominal Pain
			Black/Bloody Stools
			Colon Problems
			Constipation
			Diarrhea
			Difficult Digestion
			Distention of Abdomen
			Excessive Thirst
			Gall Bladder Problems
			Hemorrhoids
			Liver Problems
			Nausea/Vomiting

O	F	C	RESPIRATORY
			Asthma
			Chest Pain
			Chronic Cough
			Difficulty Breathing
			Lung Problems

O	F	C	CARDIO-VASCULAR
			Ankle Swelling
			Arteriosclerosis
			Atherosclerosis
			Heart Problems
			High Blood Pressure
			Irregular Heartbeat
			Low Blood Pressure
			Pain Over Heart
			Poor Circulation

O	F	C	HEENT
			Blurred Vision
			Double Vision
			Colds
			Stuffiness
			Concussion
			Difficulty Swallowing
			Ear Discharge
			Ear Noises
			Earaches
			Eye Pain
			Face/Head Numbness
			Hearing Loss
			Nasal Obstruction
			Nose Bleeds
			Slurred Speech
			Sinus Infection
			Vision Loss

O	F	C	FEMALES ONLY
			Menstrual Problems
			Menopausal Symptoms
			Vaginal Pain/Infection
			Breast Pain/Lumps
			Sexual Dysfunction
			PMS

FAMILY HISTORY

	Mother	Father	Children	Grandparents	Siblings
Cancer					
Heart Problems					
Stroke					
Diabetes					
High Blood Pressure					

Are you pregnant? _____

Date of your last period _____

My signature validates that all of the information given is accurate and reflects my current health status.

Patient Signature_____ Date_____

Signature of Authorized Person_____ Date_____

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Care Chiropractic Body Wellness Center
Notice of Privacy Policy (HIPAA)

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 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 physicians 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.

Patient Name (Print): _____ Relationship to Patient: _____

Patient Signature: _____ Date: _____

Doctor-Patient Relationship in Chiropractic

Chiropractic: It is important to acknowledge the difference between the health care specialties of Chiropractic and Medicine. Chiropractic care seeks to restore health through natural means and without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. It is important to understand what to expect from Chiropractic care.

Analysis: A Chiropractor conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). Chiropractic adjustments are the specific application of forces to facilitate the body's correction of vertebral subluxation. Our method of correction is by specific adjustments to the spine.
Diagnosis: Although Chiropractors are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every patient should be mindful of his/her own symptoms and should secure other opinions if he has any concern as to the nature of his total condition. Your Chiropractor 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: We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise. If you desire advice, diagnosis or treatment for those findings, we will recommend that you see the services of a health care provider who specialized in that area.

Results: The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal. However, in most cases there is a more gradual, but satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we admit that some conditions, which do not respond to chiropractic care, may be helped through medical science. Chiropractic and Medicine cannot always provide definite answers to all problems. The patient should discuss any questions or problems with the doctor before signing this statement of policy.

I have read and fully understand the above statement.

Patient Signature: _____ Date: _____