FOR OFFICE USE ONLY:

Name: _____

Date: _____

Doctor: _____

PATIENT HEALTH RECORD

Four Seasons Chiropractic

Welcome to Four Seasons Chiropractic Clinic!

Please fill out our confidential Patient Health Record completely and accurately. If you have any questions please do not hesitate to ask any staff member.

It is our pleasure to be of service to you. Our commitment to you is to promote the highest quality of health care via chiropractic treatment.

PATIENT INTAKE INFORMATION

Date: _____

(Legal) First Name (Legal) MI (Legal) Last Name DOB Age

Street: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____ Marital Status: [ ] S [ ] M [ ] W [ ] D

Spouse Name: _____

Language (check all that apply): [ ] English [ ] Spanish [ ] Other _____

Race/Ethnicity: [ ] White [ ] American Indian [ ] Asian [ ] Native Hawaiian/Pacific Islander

[ ] African America [ ] Latin American/Hispanic [ ] Decline to answer

Contact Info:

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Contact preference: [ ] Home Phone [ ] Cell Phone [ ] Work Phone [ ] Email [ ] Posted Mail

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Insurance Information:

Have you been in a work related accident, auto accident, or sustained a personal injury? [ ] Y [ ] N

Do you have health insurance? [ ] Y [ ] N

Please provide our staff with copies of your health insurance cards. Remember to provide ALL insurance information including Medicare cards, supplementary insurance cards, and Medicaid/Minnesota Care or Medical Assistance information.

PATIENT HISTORY

Who referred you to this office? _____

Please give a brief description of the problems you are experiencing:

_____

_____

_____

When did the problem(s) start? _____

What appears to be the initial cause of the problem(s)? _____

_____

Is there anything that makes the problem(s) better or worse? _____

_____

Are you seeing any other providers for this or any other ongoing health condition? [ ] Y [ ] N

If yes, please list the providers you are seeing: _____

_____

Have you ever been diagnosed with hypertension? [ ] Y [ ] N

Have you ever been diagnosed with diabetes? [ ] Y [ ] N

Do you smoke? [ ] Never [ ] Former [ ] Current How many packs per day? _____

Do you drink alcohol? [ ] Never [ ] Casual drinker [ ] Moderate drinker [ ] Heavy drinker

Do you consume caffeine? [ ] Never [ ] < 3 cups per day [ ] > 3 cups per day [ ] > 6 cups per day

Have you ever used drugs? [ ] Never [ ] Recreationally [ ] Addiction (past or present)

Do you exercise? [ ] Never [ ] Occasionally [ ] Weekly [ ] Daily What kind? _____

Have you had an X-ray, CT scan, or MRI in the last year? [ ] Y [ ] N

If yes where was the scan taken? _____ Body part scanned: _____

Medications: [ ] NONE

Name	Date Started	Dosage	Frequency

Allergies: [ ] NONE

Allergy	Date Of Onset (approx)	Reaction

Surgeries: [ ] NONE

Surgery	Date (approx)	Result

Hospitalizations: [ ] NONE

Reason	Date (approx)	Hospital

Have you had any abnormal test results recently from you primary doctor? [ ] Y [ ] N

If yes, please explain: _____

_____

Occupational History:

Are you: [ ] Employed [ ] Unemployed [ ] Retired [ ] Student

If you are employed, what is your current occupation? _____

FAMILY HISTORY

Relationship	History/Illnesses	Deceased Y/N
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Siblings		

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Thank you for choosing **Four Seasons Chiropractic Clinic.** We look forward to providing you with the most comprehensive chiropractic care available. Please take a few minutes to read over the following consent information. When you're finished reading, please sign this form at the bottom. If you have any questions about this consent, please ask us, we will be glad to answer any questions or concerns you may have.

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to adjust your joints. You may feel a "click" or a "pop," similar to the noise you would hear if you cracked your knuckles. Various ancillary procedures, such as hot or cold packs, electronic muscle stimulation, ultrasound, or traction may also be used during your treatment.

Possible risks: As with any health care procedure, complications are possible following chiropractic manipulation. Patients may experience stiffness or soreness after the first few days of treatment. The ancillary modalities could cause skin irritation, burn, or other minor complications. Complications could include fractures, muscular strain, ligamentous strain, dislocation of your joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to the arteries in the neck.

Probability of risks: the risks of complications due to chiropractic treatment have been described as "rare" or about as often as complications seen from taking a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in ten million, and can be further reduced by screening procedures during your initial examination. The probability of adverse reactions due to ancillary procedures is also considered rare.

Risks of remaining untreated: Delay of treatment allows for the formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult. Failure to follow your doctors recommended treatment plan may decrease your ability to get well, and may aggravate your present condition.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____

Printed Name

_____

Signature Date

AUTHORIZATION OF PAYMENT

I hereby instruct and direct _____ insurance company to pay by check or electronic payment made out and mailed/faxed directly to:

FOUR SEASONS CHIROPRACTIC

4455 North Highway 169

Plymouth, MN 55442

For the professional or medical benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for my professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed in indebtedness to the above mentioned assignee, and I have agreed to pay, in current manner, any balances of said professional service charges over and above the insurance payment. A photocopy of the assignment shall be considered as effective and valid to the original.

Signature of claimant: _____ Date: _____

AUTHORIZED SIGNATURES

Patient or authorized person's signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long term authorization card.

Signed: _____ Date: _____

Insured or authorized person's signature: I authorize payment of medical benefits for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Signed: _____ Date: _____

MEDICARE ONLY:

All doctors have been instructed to ask the following questions of all Medicare patients:

Do you or your spouse work for a company that provides you with health insurance? [ ] Y [ ] N

Are you entitled to Medicare because of End Stage Renal Disease? [ ] Y [ ] N

Is the illness or injury the result of an accident at work? [ ] Y [ ] N

Is the illness or injury the result of an accident or other injury? [ ] Y [ ] N

Has the treatment for this accident or illness been authorized by the Veterans Administration? [ ] Y [ ] N

Are you entitled to any benefits under the Federal Black Lung Program? [ ] Y [ ] N

Do you have a Medical Medigap Policy? [ ] Y [ ] N Name of Company: _____

Do you have a Medicare Supplement Policy? [ ] Y [ ] N