Patient Health Record

Patient Information

First Name: Last Name: Date:

Date of Birth: Age: Sex: ◯ Male ◯ Female Phone: - - cell/home

◯ Check if you want text reminders for apts.

Marital Status: # of children: Occupation:

Street Address: Height: ft in

City: State: Zip: Weight:

Email: Insurance Company:

Employers Name: Address: Phone: - -

Emergency Contact: Relation: Phone: - -

How did you hear about our office? If you were referred in, who referred you to our office?

Who is your primary care physician? Date and reason for last visit:

Are you receiving care from any other health care provider? ◯ Yes ◯ No What is their specialty?

Please note any significant medical history:

Current Health Conditions

What health condition(s) bring you to our office?

Have you ever received care for the condition before? ◯ Yes ◯ No If yes, please explain:

When did the condition(s) begin?

Is the purpose of this appointment related to: ◯ Chronic Discomfort ◯ Home Injury ◯ Sports

◯ Auto Injury ◯ Fall ◯ Work Injury ◯ Other:_____

If job related have you made a report of the accident to your employer? ◯ Yes ◯ No

How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Is the condition? ◯ Getting Worse ◯ Staying the same ◯ Improving ◯ Come and Gone ◯ Unsure

What makes the condition better? What makes the condition worse?

The condition(s) interferes with: ◯ Sleep ◯ Daily Routine ◯ Other Activities

Please Explain:

Last Name, First Name:

Chiropractic Experience

Have you ever been adjusted by a chiropractor? ○ Yes ○ No

If so, what was the reason for those visits?

Doctor of Chiropractic's Name? Approximate Date of Last Visit:

What would you like to gain from chiropractic care? ○ Resolve Existing Condition(s) ○ Overall Wellness ○ Both

Do you have any health concerns for any other family members today?

Health Habits

Do you smoke? ○ Yes ○ No How often?

Do you drink alcohol? ○ Yes ○ No How many drinks per week?

Do you drink coffee, tea, or soda? ○ Yes ○ No

Do you exercise regularly? ○ Yes ○ No

If so how many times per week? _____

If no, is that something you would like to improve? ○ Yes No

○

Trauma/Physical Injury History

Have you had any significant falls, injuries, or surgeries as an adult? ○ Yes ○ No If yes, explain:

Have you had any significant falls, injuries, or surgeries as a child? ○ Yes ○ No If yes, explain:

Youth or College Sports Injury? ○ Yes ○ No If yes, explain:

Any Auto Accidents? ○ Yes ○ No If yes, explain:

Any problems with flexibility? (exp. putting on socks/shoes/etc.)

How many hours a day do you typically spend sitting at a desk, computer, tablet, phone, etc?

Please **CIRCLE** each of the conditions that you have now or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and possibility of being accepted for care.

Severe or frequent headaches	Thyroid Problems	Pain in arms/legs/hands	Numbness
Heart Surgery/Pace Maker	Sinus Problems	Low Blood Pressure	Allergies
Lower Back Problems	Hepatitis	Rheumatic fever	Diabetes
Digestive Problems	Difficulty breathing	Ulcers/colitis	Asthma
Pain Between Shoulders	Kidney problems	Tuberculosis	Loss of Sleep
Congenital Heart Defect	High blood pressure	Arthritis	Dizziness
Frequent Neck Pain	Chemotherapy	Shingles	Other_____

Last Name, First Name:

Medications

○ Cholesterol ○ Blood Pressure ○ Stimulants ○ Blood Thinners ○ Glucose ○ Pain Killers

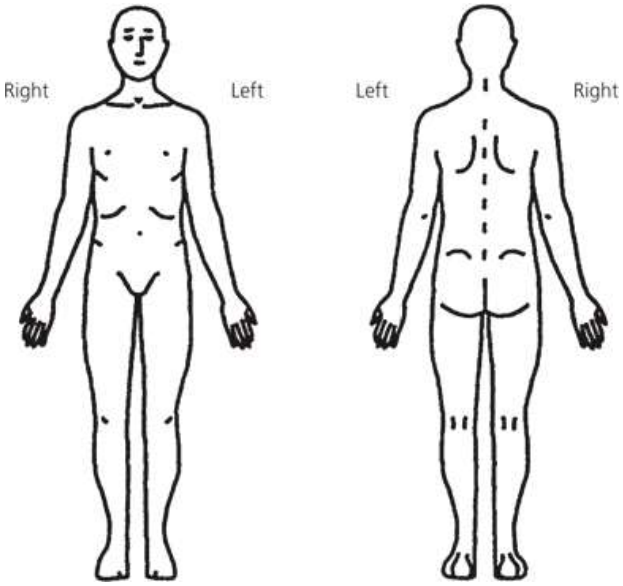
○ Aspirin/etc. ○ Muscle Relaxers ○ Insulin ○ Others:_____

Please list any vitamins or supplements that you take on a regular basis: _____

_____

Your Conditions

1) Please indicate where you are experience pain/discomfort:
X= Current. O= Past Conditions



2) Using the pain scale below, circle the level you experience when the problem/s is at its worst:

0=**No Pain**. No Discomfort
1=**Minimal Discomfort**. Minor stiffness or tightness.
2=**Mild Pain**. Noticeable pain but tolerable.
3=**Moderate**. Aggravating but still allows movement.
4=**Strong Pain**. Aggravating with minimal movement.
5=**Severe Pain**. Unbearable and no movement.

3) Please **Circle** the health concern(s) you may be experiencing now or have had in the past. Each area of concern relates to an area of the spine and function of the nerves.

Sore Throat
Stiff Neck
Radiating Arm Pain
Hand/Finger Numbness
Asthma
Allergies
High Blood Pressure
Heart Conditions

Constipation
Colitis
Diarrhea
Gas Pain
Irritable Bowel
Bladder Conditions
Menstrual Conditions
Low Back Pain
Pain or Numbness in Low Back
Reproductive Conditions

C1
C2
C3
C4
C5
C6
C7
T1
T2
T3
T4
T5
T6
T7
T8
T9
L1
L2
L3
L4
L5
S
A
C
R
A
L

Headaches
Migraines
Dizziness
Sinus Problems
Allergies
Fatigue
Head Colds
Vision Problems
Difficulty Concentrating
Hearing Problems

Mid Back Pain
Congestion
Difficulty Breathing
Bronchitis
Pneumonia
Gallbladder Conditions
Stomach Problems/Ulcers
Gastritis
Kidney Conditions

Health Goals

Check any of your health goals:

○ Improve Nutrition/Eating Habits ○ Increase Lean Muscle Mass ○ Start Exercising ○ Improve Energy

○ Weight Loss/Fat Loss ○ Reduce Stress ○ Improve Sleep ○ Reduce Pain

Improving Movement/flexibility Lower Cholesterol/Blood Pressure Improve Posture Other:_____

Last Name, First Name:

Notice of 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 disclosure for the purposes of treatment, payment, or practice of care will be made only after obtaining your consent:

1. You may request restrictions on your disclosures.
2. You may inspect and receive copies of your records within 30 days of a request.
3. You may request to view changes to your records
4. 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:

1. *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
2. *Obtain payment from third party payers.*
3. *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 I can restrict how my personal information is used or disclosed.

Patient's Name (please print): Relation to Patient (self/parent/guardian):

Signature: Date:

Terms of Acceptance

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An **adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease.

Vertebral subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health. We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any question regarding the doctor's objectives pertaining to my care in this office has been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature: Date:

Witness' Signature: Date:

Last Name, First Name:

Payment Agreement / Use of Insurance Authorization

I hereby authorize the Doctors of Inver Grove Chiropractic to work with my condition through the use of adjustments to my spine, as he/she deems appropriate. I clearly understand and agree that all services rendered by 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. Inver Grove Chiropractic, PA will not be held responsible for any preexisting 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 by me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to Inver Grove Chiropractic, PA for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Inver Grove Chiropractic 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 Inver Grove Chiropractic, PA will be credited to my account upon receipt.

Signature: Date:

Guardian/Authorized Person of Care Signature: Date:

Who should receive bills for payment on your account?

◯ Patient ◯ Spouse ◯ Parent ◯ Workers Comp ◯ Auto Insurance ◯ Medicare ◯ Health Insurance

Date of Birth:

Insurance Company: ID# Group ID:

Authorization For Care Of a Minor

I hereby authorize the doctors in the chiropractic office and whomever they may designate as their assistant to administer chiropractic care to my child through the use of adjustments and procedures the doctor deems appropriate such as mobility, massage, and any therapy the doctor seems appropriate as discussed with parent. I clearly understand and agree that all services rendered by my child 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. Dr. Amy/Ross Crain & the Doctors of Inver Grove Chiropractic will not be held responsible for any pre-existing medically diagnosed condition or for any medical diagnosis. I also understand if I suspend or terminate my child's care for any reason, any fees for professional services rendered will become immediately due and payable. I hereby authorize assignment of my child's insurance rights and benefits (if applicable) directly to the provider for services rendered. I authorize the use of this signature to allow the insurance company to pay Inver Grove Chiropractic, PA directly any amount payable as my child's assignment of benefits. I authorize the use of this signature on any insurance submissions.

Name of Child:

Parent or Guardian Authorizing Care's Name (please print): Birthdate:

Signature of Parent or Guardian: Date:

X-ray Consent

I hereby give my consent to Inver Grove Chiropractic and it's representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant. I have read and understood all the above information.

Patient Signature: Date:

Last Name, First Name:

HIPPA Right of Access Form for Family Member/Friend

I,_____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: Relationship:

Address:

Phone:

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

1. A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
2. B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
    1. Mental health records
    2. Communicable diseases (including HIV and AIDS)
    3. Alcohol/drug abuse treatment
    4. Other (please specify):
    5. _____
    6. _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

1. An electronic record or access through an online portal
2. Hard copy

This authorization shall be effective until (Check one):

1. All past, present, and future periods, OR
2. Date or event:_____
   unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Name of Individual Giving this Authorization (please print): Date of Birth:

Signature of Individual Giving this Authorization: Date:

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524