WE CAN HELP YOU
FAMILY HEALTH TRUST CHIROPRACTIC CENTER
952-933-4427
www.familyhealthtrust.com
12321 Minnetonka Blvd,
Minnetonka, MN 55305

Name: _____ Date: _____

Birth Date: _____ Age: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Home Telephone: ( ) _____ Cell: ( ) _____

Email: _____

Occupation: _____

Employer Name: _____

Employer Address: _____

_____

Single: _____ Married: _____ Spouse's Name: _____

Have you seen a Chiropractor before? **Yes** | **No** If yes, when? _____

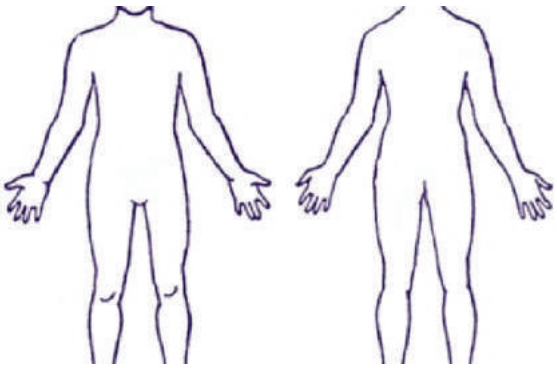
Whom may we thank for referring you to our office? _____

Your Health Summary

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

- ☐ Headaches
- ☐ Pins and Needles in Legs
- ☐ Fainting
- ☐ Neck Pain
- ☐ Pins and Needles in Arms
- ☐ Loss of Smell
- ☐ Back Pain
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Buzzing in ears
- ☐ Ringing in ears
- ☐ Stomach upset
- ☐ Numbness in fingers
- ☐ Numbness in toes
- ☐ Loss of taste
- ☐ Tension
- ☐ Fatigue
- ☐ Depression
- ☐ Irritability
- ☐ Nervousness
- ☐ Sleeping problems
- ☐ Neck Stiffness
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Diarrhea
- ☐ Constipation
- ☐ Shoulder Pain
- ☐ Ankle Pain
- ☐ Cold Sweats
- ☐ TMJ Pain
- ☐ Problem Urinating
- ☐ Heartburn
- ☐ Mood Swings
- ☐ Menstrual Pain
- ☐ Menstrual Irregularity
- ☐ Ulcers

Mark the areas of chief complaint:



List any medications you're taking:

_____

_____

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Patient HIPAA Consent Form

The Department of Health Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can within the required laws, to secure and protect that privacy. We strive to always take reasonable precautions to protect you privacy. When it is appropriate and necessary, we provide the minimum necessary information about treatment, payment or health care operations, in order to provide health care that is in your best interests.

We also want you to know that we support your full access to your personal medical records with in the state and federal laws. We may have indirect treatment relationships with you (such as laboratories or scans centers that interact with our doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the user of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to consent in this document, at some future time, you may request to refuse all or part of you PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. However, we are not obligated to alter internal policies to conform to your request.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

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Informed Consent to Care

You are the decision maker for you health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot of cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headaches. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involved manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatments options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescriptions drugs, physical therapy, bracing, injections and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent, I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ **Signature:** _____ **Date:** _____

Parent or Guardian: _____ **Signature:** _____ **Date:** _____

Witness Name: _____ **Signature:** _____ **Date:** _____

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Financial Policy & Assignment of Benefits

I authorize Dr. John Cole Sheehan DBA Family Health Trust PC to act as my agent in helping me obtain payment form my insurance company. I authorize use of this form on all my submissions.

I authorize release of pertinent information required to process my claims to my insurance company.

I authorize payment direct to Family Health Trust PC. This payment will not exceed my indebtedness to Dr. John Cole Sheehan DBA Family Health Trust PC, and I have agreed to pay any insurance balances over and above the insurance payment.

I understand that I am responsible for my bill regardless of my insurance status. I also understand that Dr. John Cole Sheehan DBD Family Health Trust PC is not party to the contract between my employer, my insurance company and myself.

A photocopy of the Assignment of Benefits shall be considered as effective and valid as the original.

Insurance Company Name: _____

ID#: _____ Group#: _____

Secondary Insurance: _____

___ **I do not have chiropractic insurance coverage. I am responsible for my bill.**

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____