Confidential Patient Health Record

Date:	I.D. #:

GO HEALTH CHIROPRACTIC

PERSONAL HISTORY

Referred to this Office by:_____

Name_____ Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Birth Date_____ Age:_____ Sex: ☐ M ☐ F

Cell Phone_____ Height _____ Weight _____

E-mail Address_____ Social Security #_____

Driver's License Number_____ Business Employer_____

Type of Work_____Business Phone_____

Circle one: Married Single Widowed Divorced Separated Name of Spouse_____

Spouse's Social Security #_____

Spouse's Employer_____ Type of Work_____

Business Phone_____ Name and Ages of Children_____

Name and Number of Emergency Contact_____ Relationship_____

Who is Responsible for the Bill, You and ☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid

☐ Personal Health Insurance (Name)_____ ☐ Health Card #_____

Insured Person's Name _____ Date of Birth_____

CURRENT HEALTH CONDITION

Unwanted Health Condition(s): 1st _____ _____

2nd _____ _____

3rd _____ _____

4th _____ _____

Tell us how we can help: _____

_____

_____

_____

_____

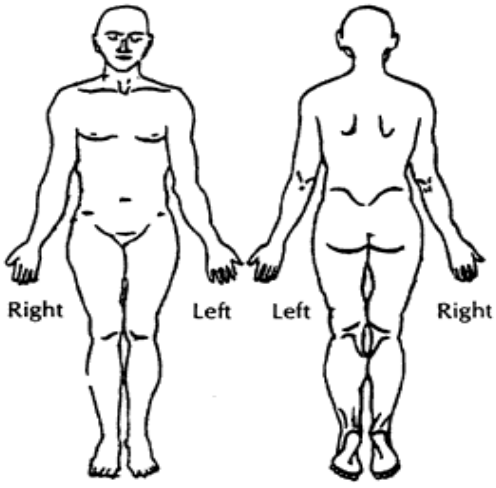
_____

_____

_____

How would you describe the quality of pain (if applicable) in your worst area?

- □ Sharp
- □ Dull
- □ Diffuse
- □ Achy
- □ Burning
- □ Shooting
- □ Numb
- □ Tingly
- □ Sharp with motion
- □ Shooting with motion
- □ Stabbing with motion
- □ Electric like with motion



Please outline on the diagram the area of your discomfort.

 4101-D W. Broadway Robbinsdale, MN 55422 Tel: 763-533-9997 Fax: 763-533-6058 www.gohealthchiro.com

Other doctors seen for this condition: ☐ Yes ☐ No_____ Who?_____

Type of Treatment_____ Results_____

When Did The Condition Begin?_____ Has This Condition Occurred Before? ☐ Yes ☐ No

Is Condition: ☐ Work Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other_____

Date of Accident_____ Time of Accident_____

Have You Made a Report of Your Accident to Your Employer/Supervisor?: ☐ Yes ☐ No

List all prescription/Over the counter Medications/Supplements you are taking: _____

_____

Do You Wear A Shoe Inserts/Orthotics? ☐ Yes ☐ No

PAST HEALTH HISTORY

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other_____

Major Accident, Prior Auto Accident, Work Accident or Falls (Include Date): _____

_____

Hospitalization (Other than Above)_____

_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit_____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES <u>YOU HAVE HAD</u>:

☐ Pneumonia
☐ Rheumatic Fever
☐ Polio
☐ Whooping Cough
☐ Anemia
☐ Measles
☐ Mumps
☐ Small Pox
☐ Chicken Pox
☐ Cancer
☐ Heart Disease
☐ Thyroid
☐ Influenza
☐ Pleurisy
☐ Epilepsy
☐ Mental Disorders
☐ Lumbago
☐ Eczema

INTAKE
☐ Coffee
☐ Alcohol
☐ Cigarettes
☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING <u>YOU HAVE HAD</u> THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE
☐ Low Back Pain
☐ Pain Between Shoulders
☐ Neck Pain
☐ Arm Pain
☐ Joint Pain/Stiffness
☐ Walking Problems
☐ Difficult Chewing/Clicking Jaw
☐ General Stiffness

☐ Gas/Bloating After Meals
☐ Heartburn
☐ Black/Bloody Stool
☐ Colitis

GENITO-URINARY CODE
☐ Bladder Trouble
☐ Painful/Excessive Urination
☐ Discolored Urine

FEMALES ONLY:
When was your last period?
_____

Are you pregnant?
☐ Yes ☐ No ☐ Not Sure

NERVOUS SYSTEM CODE
☐ Nervous
☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Confusion/Depression
☐ Fainting
☐ Convulsions
☐ Cold/Tingling Extremities
☐ Stress

C-V-R CODE
☐ Chest Pain
☐ Short Breath
☐ Blood Pressure Problems
☐ Irregular Heartbeat
☐ Heart Problems
☐ Lung Problems/Congestion
☐ Varicose Veins
☐ Ankle Swelling
☐ Stroke

GENERAL CODE
☐ Fatigue
☐ Allergies
☐ Loss of Sleep
☐ Fever
☐ Headaches

EENT CODE
☐ Vision Problems
☐ Dental Problems
☐ Sore Throat
☐ Ear Aches
☐ Hearing Difficulty
☐ Stuffed Nose

GASTRO-INTESTIONAL CODE
☐ Poor/Excessive Appetite
☐ Excessive Thirst
☐ Frequent Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Hemorrhoids
☐ Liver Problems
☐ Gall Bladder Problems
☐ Weight Trouble
☐ Abdominal Cramps

MALE/FEMALE CODE
☐ Menstrual Irregularity
☐ Menstrual Cramps
☐ Vaginal Pain/Infection
☐ Breast Pain/Infection
☐ Prostate/Sexual Dysfunction
☐ Other Problems
☐ _____
☐ _____
☐ _____

FAMILY HISTORY
I have an immediate family member that has:

☐ Rheumatoid Arthritis
☐ Diabetes
☐ Lupus
☐ Heart Problems
☐ Cancer
☐ ALS
☐ _____

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (corrective care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Check here if you want our doctors to select the type of care appropriate for your condition.

Relief Care
Relief Care is that care necessary to get rid of your symptoms of pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care
Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Here are our office hours, please circle the day of the week along with the morning or afternoon that you are available.

Monday	8:30am-12:15pm	&	2:30-5:45pm
Tuesday	N/A		2:30-5:45pm
Wednesday	8:30am-12:15pm	&	2:30-5:45pm
Thursday	8:30am-12:15pm	&	2:30-5:45pm
Friday	8:30am-12:15pm		N/A

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AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. 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.

If I am being seen for injuries as a result of a motor vehicle accident or work related injury and have hired a legal representative, I authorize and request my attorney to pay Go Health Chiropractic directly for my medical expenses from my pending claim for damages related to the accident I am being seen for. Furthermore, if no recovery is made on my behalf, I accept full responsibility for all charges.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office*.*

*Patient's Signature:*_____ *Date:*_____

*Guardian's Signature Authorizing Care:*_____ *Date:*_____