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CHIROPRACTIC & WELLNESS

Patient Information

Contact Information

Name _____ Preferred Name _____

Email address _____ Pronouns _____

Primary Phone Number (_____) _____ ☐ Mobile ☐ Home ☐ Work

Additional Phone Number (_____) _____ ☐ Mobile ☐ Home ☐ Work

Address _____

City _____ State _____ Zip Code _____

Sex ☐ Male ☐ Female Gender _____ Birth Date _____ / _____ / _____ Age _____

If a minor, Parent/Guardian Name(s) _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow Number of Children _____

Occupation _____ Employer/School_____

Work/Student Status ☐ Full time ☐ Part time

Preferred Appointment Reminder Notification Method(s) ☐ Email ☐ Text ☐ Both

How did you hear about us? _____

Insurance Information

Insurance Company _____

Policy Holder: ☐ Self ☐ Spouse ☐ Parent

Policy Holder Name _____ Birth Date _____ / _____ / _____

Policy Holder Address (if different from above) _____

City _____ State _____ Zip Code _____

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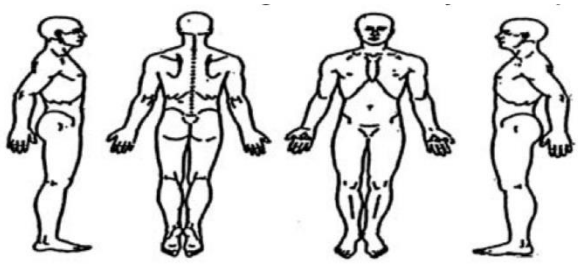
Health History

Patient Name _____ **Today's Date** _____

What's bringing you in today? _____

Please indicate on the drawings below where you have pain/symptom(s):



What do you think caused your problem? _____

How long have you had this problem? _____

How often do you experience your symptoms?

☐ Constantly (76-100% of the time)
☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time)
☐ Intermittently (1-25% of the time)

How would you describe the type of pain?

☐ Sharp
☐ Dull
☐ Diffuse
☐ Achy
☐ Burning
☐ Shooting
☐ Stiff
☐ Numb
☐ Tingly
☐ Sharp with motion
☐ Shooting with motion
☐ Stabbing with motion
☐ Electric with motion
☐ Other: _____

Using a scale from 0-10 (with 10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10

How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

What makes your pain worse? _____

What makes your pain better? _____

Who else have your seen for this problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER Physician ☐ Orthopedist ☐ Other: _____
☐ Massage Therapist ☐ Physical Therapist ☐ No one

Any other details to share about your current pain/symptoms? _____

What is your: **Height** _____ **Weight** _____ **Age** _____
Occupation _____

How would your rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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What type of exercise do you do? ☐ Strenuous ☐ Moderate ☐ Light ☐ None

Indicate if you have any immediate family members with any of the following:

☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus
☐ Heart Problems ☐ Cancer ☐ Other: _____

For each of the conditions listen below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed, place a check in the "present." Leave blank if it does not apply.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High blood pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart attack	☐	☐	Excessive thirst
☐	☐	Upper back pain	☐	☐	Chest pains	☐	☐	Frequent urination
☐	☐	Mid back pain	☐	☐	Stroke	☐	☐	Smoking/tobacco use
☐	☐	Low back pain	☐	☐	Angina	☐	☐	Drug dependence
☐	☐	Shoulder pain	☐	☐	Kidney stones	☐	☐	Alcohol dependence
☐	☐	Elbow/upper arm pain	☐	☐	Kidney disorders	☐	☐	Allergies
☐	☐	Wrist pain	☐	☐	Bladder infection	☐	☐	Depression
☐	☐	Hand pain	☐	☐	Painful urination	☐	☐	Systemic Lupus
☐	☐	Hip pain	☐	☐	Loss of bladder control	☐	☐	Epilepsy
☐	☐	Upper leg pain	☐	☐	Prostate problems	☐	☐	Dermatitis/eczema/rash
☐	☐	Knee pain	☐	☐	Abnormal weight change	☐	☐	HIV/AIDS
☐	☐	Ankle/foot pain	☐	☐	Loss of appetite	☐	☐	Hypo/hyperthyroidism
☐	☐	Jaw pain	☐	☐	Abdominal pain	☐	☐	Other: _____
☐	☐	Joint pain/stiffness	☐	☐	Ulcer			
☐	☐	Arthritis	☐	☐	Hepatitis	*Females:*		
☐	☐	Rheumatoid arthritis	☐	☐	Liver/Gall bladder issues	☐	☐	Pregnancy
☐	☐	Cancer, _____	☐	☐	General fatigue	☐	☐	Endometriosis
☐	☐	Tumor	☐	☐	Muscular incoordination	☐	☐	PCOS
☐	☐	Asthma	☐	☐	Visual disturbances	☐	☐	Irregular menses
☐	☐	Chronic sinusitis	☐	☐	Dizziness	☐	☐	PMDD

List all prescription medications you are currently taking:

_____

List all over-the-counter medications/supplements you are currently taking:

_____

List all surgical procedures you have had:

_____

Have you had significant past trauma? ☐ No ☐ Yes, _____

Anything else pertinent to your visit today? _____

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Receipt of Notice for Privacy Practices

I hereby acknowledge receipt of the Notice of Privacy Practices for Evergreen Chiropractic (formally known as “Jackson Chiropractic Clinic”) regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized, and disclosed by the Clinic and my respective rights therein. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting (651) 483-4321.

My signature below herein constitutes acknowledgment that I have been furnished a copy of the Notice of Privacy Practices for Jackson Chiropractic Clinic.

Payment Agreement

I authorize the release of any medical information necessary to process insurance billings.

I authorize payment and assignment of insurance benefits to the doctor’s office.

I am personally responsible for supplying accurate and current information.

I understand I am financially responsible for all charges and deductibles not covered by my insurance and/or if I supply false or incorrect billing information. I authorize a photocopy of this statement to serve as an original.

Patient Name: _____

Patient Signature: _____ Date: _____

Signature of Parent of Guardian (if a minor): _____

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Informed Consent Document

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

Nature of Chiropractic Care. The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way to move your joints. That may cause an audible noise, and you may feel a sense of movement.

Analysis, Examination, Treatment. As part of the analysis, examination, and treatment, you are consenting to the following procedures, but not limited to:

Spinal manipulative therapy	Range of motion testing	Therapeutic ultrasound
Palpation	Orthopedic testing	Hot/cold therapy
Vital signs	Basic neurological testing	Electric muscle stimulation
	Radiographic studies	

Risk Inherent with Chiropractic Care. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. The Doctor will make every reasonable effort during the examination to screen for contraindications of care. These complications include, but are not limited to: muscle strain, burns, fractures, disc injuries, dislocations, cervical myelopathy, and costovertebral stains and separations. Some patients will feel some stiffness and soreness following the first few days of treatment.

Other Available Treatment Options. Other treatment options for your condition may include self-administered over-the-counter analgesics, rest, medical care, prescription drugs, hospitalization, and surgery. If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physicians.

Risk of Remaining Untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my care provider(s) and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name: _____

Patient Signature: _____ Date: _____

Signature of Parent of Guardian (if a minor): _____

Doctor Name: _____

Doctor Signature: _____ Date: _____