



**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) \_\_\_\_\_

Parent/Guardian Phone \_\_\_\_\_ Email \_\_\_\_\_

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? \_\_\_\_\_

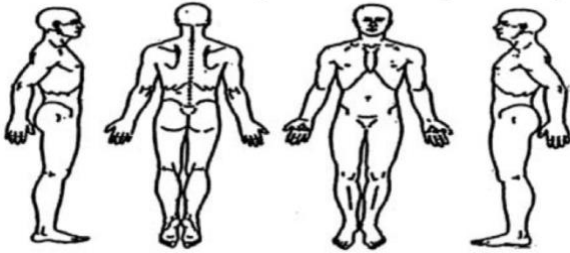


## Chiropractic Health History

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?

- |   |   |
|---|---|
| <input type="checkbox"/> Constantly (76-100% of the time) | <input type="checkbox"/> Occasionally (26-50% of the time)  |
| <input type="checkbox"/> Frequently (51-75% of the time)  | <input type="checkbox"/> Intermittently (1-25% of the time) |

How would you describe the type of pain?

- |                                   |   |
|-----------------------------------|---|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Numb                 |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Tingly               |
| <input type="checkbox"/> Diffuse  | <input type="checkbox"/> Sharp with motion    |
| <input type="checkbox"/> Achy     | <input type="checkbox"/> Shooting with motion |
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Stabbing with motion |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric with motion |
| <input type="checkbox"/> Stiff    | <input type="checkbox"/> 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?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Getting Worse | <input type="checkbox"/> Staying the Same | <input type="checkbox"/> Getting Better |
|--|---|---|

What makes your pain worse? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

How has this issue affected your activities of daily living? \_\_\_\_\_

Who else have you seen for this problem?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chiropractor      | <input type="checkbox"/> Neurologist        | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> Acupuncturist     | <input type="checkbox"/> Orthopedist        | <input type="checkbox"/> Other: _____           |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> No one                 |

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

What are your goals with chiropractic care? \_\_\_\_\_



What is your: **Height** \_\_\_\_\_ **Weight** \_\_\_\_\_ **Age** \_\_\_\_\_  
**Occupation** \_\_\_\_\_

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

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	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/tobacco use
<input type="checkbox"/>	<input type="checkbox"/>	Upper back pain	<input type="checkbox"/>	<input type="checkbox"/>	Chronic sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Drug dependence
<input type="checkbox"/>	<input type="checkbox"/>	Mid back pain	<input type="checkbox"/>	<input type="checkbox"/>	High/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol dependence
<input type="checkbox"/>	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Allergies, _____
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/upper arm pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Wrist pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Hand pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disorders	<input type="checkbox"/>	<input type="checkbox"/>	ADD
<input type="checkbox"/>	<input type="checkbox"/>	Hip pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder infection	<input type="checkbox"/>	<input type="checkbox"/>	Autism
<input type="checkbox"/>	<input type="checkbox"/>	Upper leg pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Knee pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of bladder control	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/foot pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/eczema/rash
<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal weight change	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Joint pain/stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Hypo/hyperthyroidism
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Acid reflux/GERD	<i>Females:</i>		
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall bladder issues	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	General fatigue	<input type="checkbox"/>	<input type="checkbox"/>	PCOS
<input type="checkbox"/>	<input type="checkbox"/>	Ehlers Danlos	<input type="checkbox"/>	<input type="checkbox"/>	Muscular incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Irregular menses
<input type="checkbox"/>	<input type="checkbox"/>	Cancer, _____	<input type="checkbox"/>	<input type="checkbox"/>	Visual disturbances	<input type="checkbox"/>	<input type="checkbox"/>	PMDD
<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness			

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? \_\_\_\_\_



**Perinatal Health History**

**Patient Name** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

**Due date (or delivery date):** \_\_\_\_\_

**# weeks pregnant (or at time of delivery)** \_\_\_\_\_

**How many children do you have?** \_\_\_\_\_ **How many pregnancies have you had?** \_\_\_\_\_

**If you have children, how were they delivered?**     Vaginally     C-section

**Did you undergo any fertility treatments to get pregnant?**  No     Yes, describe: \_\_\_\_\_

**Where do you (or did you) plan to give birth?** \_\_\_\_\_

**Name of Obstetrician/Midwife/ Group** \_\_\_\_\_

**Are you using a doula?**     No     Yes, name: \_\_\_\_\_

**What are your hopes or expectations for the birth? Or, which describes your birth? (check all that apply)**

- Natural birth     Epidural, if necessary     Definite epidural     VBAC  
 Planned C-section     Planned induction     Other: \_\_\_\_\_

**What prenatal vitamin(s) are you taking?** \_\_\_\_\_

**During pregnancy, do you (or did you) use/experience any of the following?**

- Over the counter medications  No     Yes, \_\_\_\_\_  
High blood pressure     No     Yes, \_\_\_\_\_  
Gestational diabetes     No     Yes, \_\_\_\_\_  
Anemia     No     Yes, \_\_\_\_\_  
Morning sickness     No     Yes, \_\_\_\_\_  
Abnormal bleeding     No     Yes, \_\_\_\_\_

**Is there anything else we should know about your pregnancy and/or birth story?**

\_\_\_\_\_

**What are your pregnancy/post-partum goals?**

\_\_\_\_\_



**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: \_\_\_\_\_



**Payment Information & Agreement  
Chiropractic**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**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 \_\_\_\_\_

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

Patient Initials

**Financial Responsibility Acknowledgment**

I understand that **co-pays are due at the time of service.**

If I have **not yet met my deductible** and no co-pay is required, I agree to pay a **\$45 down payment** toward my account at the time of service. This payment will be applied to any charges determined by my insurance provider once claims are processed. I acknowledge that the final amount I owe may be **more than \$45**, in which case I will be billed for the remaining balance.

**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 Initials



Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Credit Card on File Authorization**

Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_ Security Code \_\_\_\_\_ Zip Code \_\_\_\_\_

While keeping a credit card on file is **not required**, it is **highly encouraged** for your convenience. Please indicate your preferred method of handling charges:

- Please charge my card for any and all charges, including balances remaining after insurance payments are processed.**

I authorize automatic charges to my card on file for co-pays, co-insurance, deductibles, and any remaining balances as they are billed.

- Please charge my card only after I have reviewed and approved each charge.**

You will contact me for confirmation before charging my card on file. I understand I am still expected to pay upon receipt of my statement.

- Do not charge my card on file.**

I understand I am responsible for all balances and will pay by another method upon receiving a statement.

Signature \_\_\_\_\_ Date \_\_\_\_\_



**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 Evergreen Chiropractic.**

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent of Guardian (if a minor): \_\_\_\_\_