Perreault Chiropractic

Dr. Roger E. Perreault, DC *Dr. Nicole R. Perreault, DC, L.Ac*
Phone: (320) 358-3441 / Fax: (320) 358-3624
263 West 4th St, P.O. Box 86 Rush City, Minnesota 55069
Family Chiropractic **Acupuncture** **Automobile Injury**

Confidential Patient History **Date: ___/___/_____**

Name (Including Middle Initial): ____

Gender: □ **Male** □ **Female** **Preferred Language:** ____________ **Marital Status:** □ **M** □ **S** □ **W** □ **D** □ **O**

Address: ______________________________________ **Number of Children:** _______

City: ___________ **State:** _____ **Zip Code:** ________ **Social Security Number:** ______________

Age: _____ **Birth Date:** ___/___/______

Home Phone: ___________________________ **Cell Phone:**___________________________

Email Address: _____________________@_______________

Preferred Contact Method: □ **Home** □ **Cell** □ **Email**

Occupation: ____________________________ **Employer:** ___________________________

Address: ______________________________ **Work Phone:** ________________________

Name of Spouse: _________________________ **Phone Number:** ______________________

Name of Insurance Company: ____

Name of Emergency Contact (Not Spouse): ___________________ **Phone:** _________________

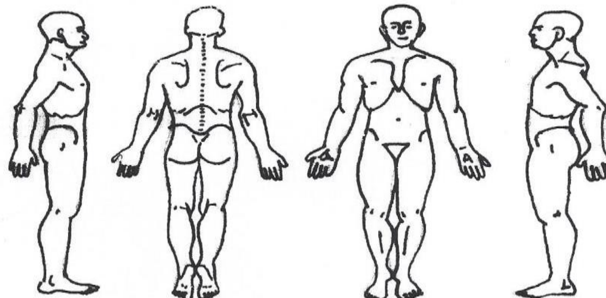
How do you prefer to be verbally addressed? _____________________________________

Whom may we ask is referring you? ____

Present complaint: ____

____

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING, ETC.



Patient Name: ____

When did your problem begin? Is there a specific date? ____

How did your problem begin? ____

____

Have you had anything similar to this in the past? □ Yes □ No If so, please explain: _____________

____

Please describe the Character of your current pain. Check all that apply:

□ Sharp □ Stabbing □ Burning □ Shooting □ Aches □ Soreness □ Weakness

□Throbbing □ Numbness □ Dull □ Constricting □ Stiff □ Other (_______________)

On a scale from 0 – 10, with 10 being the worst pain you have experienced and 0 being no pain, what is your current rating of pain?

0 1 2 3 4 5 6 7 8 9 10

How often are the complaints present?

□ Constant (100%) □ Frequent (75%) □ Intermittent (50%) □ Occasional (25%)

Is the pain: □ Increasing □ Decreasing □ Not Changing □ Varies

Pain is aggravated by: □ Walking □ Sitting □ Standing □ Riding in a car □ Lifting □ Bending

□ Stretching □ Twisting □ Running □ Transitioning from sitting to standing

□ Other (____)

Pain is reduced by: □ Medicine □ Exercise □ Rest □ Physical Therapy □ Supplements

Other: ____

What would you like to do, but can't, because of your pain? ____

Are your complaints affecting your ability to work or be active? □ Yes □ No □ For Some Things

Is there dizziness associated with symptoms? □ Yes □ No If so, when? ____________________

Any fever or chills? □ Yes □ No ____

Any change in bowel or bladder function? □ Yes □ No _____________________________________

Are your complaints affecting your ability to sleep? □ Yes □ No Explain: ____________________

On average, how many hours of sleep do you get per night? 1 2 3 4 5 6 7 8 9 10

Do you sleep through the night uninterrupted? □ Yes □ No _________________________________

For your present complaint, have you seen any other doctors or had any physical therapy? □ Yes □ No

If yes, who? ________________________________ **What treatment?** ________________________________

Patient Name: ____

Family Doctor/Primary Care Physician: ____

Have you had surgery for any reason? □ Yes □ No **Explain:** ____________________________

Have you ever been in an accident? □ Yes □ No **Explain:** _______________________________

What supplements are you taking? ____

For each of the conditions listed below, place a check in the past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the present column.

Past	*Present*		*Past*	*Present*		*Past*	*Present*	
☐	☐	**Headaches**	☐	☐	**Visual Disturbances**	☐	☐	**Kidney Disorders**
☐	☐	**Neck pain**	☐	☐	**Dizziness**	☐	☐	**Bladder Infection**
☐	☐	**Upper Back Pain**	☐	☐	**Diabetes**	☐	☐	**Painful Urination**
☐	☐	**Mid Back Pain**	☐	☐	**Excessive Thirst**	☐	☐	**Loss of Bladder Control**
☐	☐	**Low Back Pain**	☐	☐	**Frequent Urination**	☐	☐	**Prostate Problems**
☐	☐	**Shoulder Pain**	☐	☐	**Smoking/Tobacco Use**	☐	☐	**Weight Loss/Gain**
☐	☐	**Upper Arm Pain**	☐	☐	**Drug/Alcohol Dependence**	☐	☐	**Loss of Appetite**
☐	☐	**Wrist Pain**	☐	☐	**HIV/AIDS**	☐	☐	**Abdominal pain**
☐	☐	**Hand Pain**	☐	☐	**Allergies**	☐	☐	**Ulcers**
☐	☐	**Hip Pain**	☐	☐	**Depression**	☐	☐	**Hepatitis**
☐	☐	**Lower Leg Pain**	☐	☐	**Systemic Lupus**	☐	☐	**Gall Bladder Disorder**
☐	☐	**Ankle/Foot Pain**	☐	☐	**High Blood Pressure**	☐	☐	**Cancer**
☐	☐	**Jaw Pain**	☐	☐	**Kidney Stones**	☐	☐	**Asthma**
☐	☐	**Joint Swelling**	☐	☐	**Heart Attack**	☐	☐	**Chronic Sinusitis**
☐	☐	**Arthritis**	☐	☐	**Chest Pains**	☐	☐	**Epilepsy**
☐	☐	**Rheumatoid Arthritis**	☐	☐	**Stroke**	☐	☐	**Birth Control Pills**
☐	☐	**General Fatigue**	☐	☐	**Angina**	☐	☐	**Hormonal Replacement**
☐	☐	**Muscular Incoordination**				☐	☐	**Pregnancy**

Other Health Concerns: ____

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Consent to the Use and Disclosure of Health information for Treatment, payment, or Healthcare operations.

I understand that as part of my healthcare, Perreault Chiropractic originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses treatment, and any future plans for care or treatment. I understand that this information serves as:

- **A basis for planning my care and treatment.**
- **A means of communication among the many healthcare professionals who contribute to my care.**
- **A source of information for applying my diagnosis and surgical information to my bill.**
- **A means by which a third-party payer can verify that services billed were actually provided.**
- **A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.**

I understand and have been provided with a "Notice of Privacy Practices" that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Perreault Chiropractic reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations ad that Perreault Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Perreault Chiropractic has already taken action in reliance thereon.

Authorization and Assignment of Benefits

I hereby authorize Perreault Chiropractic to release to my insurance company information necessary for them to process my claims for care. I also assign insurance benefits to Perreault Chiropractic as may be allowed by my insurance company. I further understand that I am fully responsible for all the charges incurred at Perreault Chiropractic regardless of my insurance coverage. Please note: We will do all we can to insure your care is covered by your insurance carrier. However, benefits quoted to us over the phone are not a guarantee of payment but a general outline of your coverage. If a problem arises we will appraise you as soon as possible and will expect you to call your insurance carrier to clear up any problems. Please keep in mind your contract is between you and your insurance carrier. We do not have any legal rights to your insurance contract – you do. Please be aware that many insurance carriers can take up to 3 months or more to process a claim

Signature: ____ Date: ________________