

Perreault Chiropractic

Confidential Patient History

Date: / /

Name (Including Middle Initial): _____

When/How did your problem begin? (specific date?) _____

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 Frequent Intermittent Occasional

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: _____

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: _____

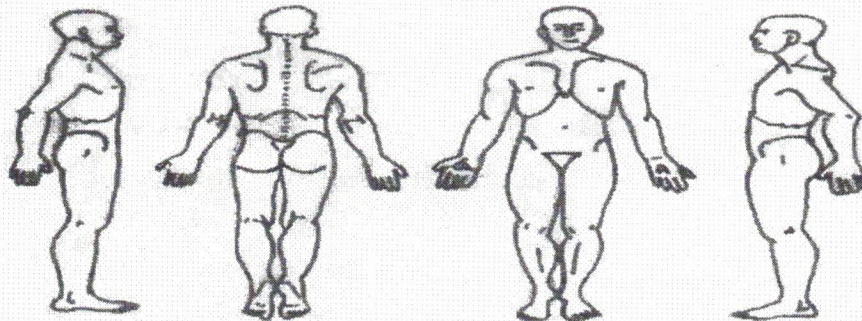
Do you sleep through the night uninterrupted? Yes No _____

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

If yes, who? _____ What treatment? _____

Present complaint: _____

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



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

- Headaches
- Neck pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Shoulder Pain
- Upper Arm Pain
- Wrist Pain
- Hand Pain
- Hip Pain
- Lower Leg Pain
- Ankle/Foot Pain
- Jaw Pain
- Joint Swelling
- Arthritis
- Rheumatoid Arthritis
- General Fatigue
- Muscular Incoordination

Past Present

- Visual Disturbances
- Dizziness
- Diabetes
- Excessive Thirst
- Frequent Urination
- Smoking/Tobacco Use
- Drug/Alcohol Dependence
- HIV/AIDS
- Allergies
- Depression
- Systemic Lupus
- High Blood Pressure
- Heart Attack
- Pregnancy
- Chest Pains
- Stroke
- Angina
- Kidney Stones

Past Present

- Kidney Disorders
- Bladder Infection
- Painful Urination
- Loss of Bladder Control
- Prostate Problems
- Weight Loss/Gain
- Loss of Appetite
- Abdominal pain
- Ulcers
- Hepatitis
- Gall Bladder Disorder
- Cancer
- Asthma
- Chronic Sinusitis
- Epilepsy
- Birth Control Pills
- Hormonal Replacement

Other Health Concerns: _____

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

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 and 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: _____