Patient Name_____ **Current Date**_____

What type of regular exercise do you perform (circle one)
None Light Moderate Strenuous

What is your height?
_____Feet_____Inches

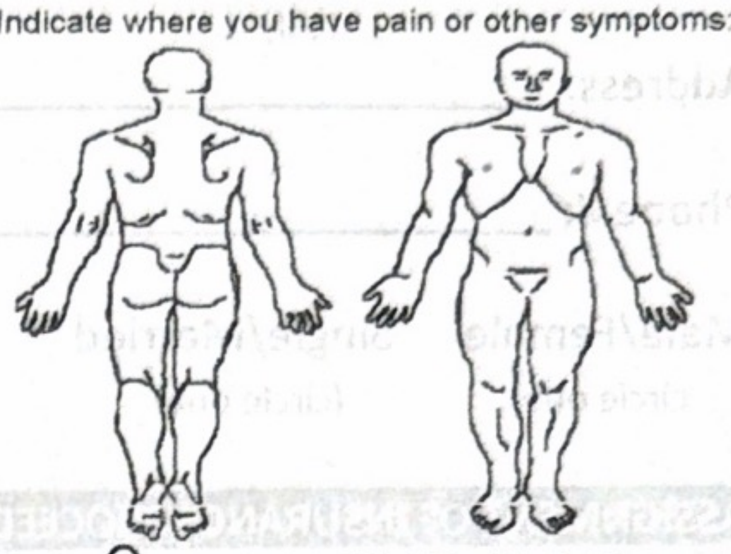
What is your weight?
_____ Lbs

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on: | | | |

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**

Past week: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**

4. How often do you experience your symptoms?

(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. How is your condition changing, since care began at *this* facility?

(0) N/A — This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

For each of the conditions 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	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke	○	○	Depression
○	○	Low Back Pain	○	○	Angina	○	○	Systemic Lupus
○	○	Shoulder Pain	○	○	Kidney Stones	○	○	Epilepsy
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Dermatitis/Eczema/Rash
○	○	Wrist Pain	○	○	Bladder Infection	○	○	HIV/AIDS
○	○	Hand Pain	○	○	Painful Urination	○	○	Chronic Sinusitis
○	○	Hip/Upper Leg Pain	○	○	Loss of Bladder Control	○	○	Asthma
○	○	Knee/Lower Leg Pain	○	○	Prostate Problems	○	○	Tumor
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss	○	○	Cancer
○	○	Jaw Pain	○	○	Loss of Appetite	○	○	Hepatitis
○	○	Joint Swelling/Stiffness	○	○	Abdominal Pain	○	○	Ulcer
○	○	Arthritis	○	○	Liver/Gall Bladder Disorder	***Females Only***		
○	○	Rheumatoid Arthritis	○	○	General Fatigue	○	○	Birth Control Pills
○	○	Muscular Incoordination	○	○	Visual Disturbances	○	○	Hormonal Replacement
○	○	Dizziness	○	○	Drug/Alcohol Dependence	○	○	Pregnant
						Ever had a Mammogram?	○ Yes	○ No

Indicate if an immediate family member has hand any of the following:(circle all that apply)
Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus Other _____

Any drug allergies? Yes_____ No _____, If yes, please list allergies _____

Have you had any surgical procedures or even been hospitalized? Yes_____ No_____

If yes, please list the procedures and dates? _____

_____

Patient Signature:_____ **Office Use Only/Acct #**_____

Mahtomedi Chiropractic Clinic
130 Hickory Street, Mahtomedi, MN 55115

Patient Name: _____ **Birth Date:** _____
(Last) (First) (Middle Initial)

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Email Address:** _____

Male/Female **Single/Married** **Who may we thank for referring you** _____
circle one) (circle one)

ASSIGNMENT OF INSURANCE PROCEED Initial _____

If you have insurance, please sign this assignment of benefits agreement. By agreeing to this assignment, we will direct your insurance company to make any payments for your chiropractic, physiotherapy, Physical rehabilitation, x-rays, diagnostic testing or any other reimbursable treatment or evaluations you receive to our clinic directly. In exchange for services and supplies rendered, I do assign to the treating physician any insurance proceeds, including accident and health insurance, auto insurance benefits and bodily injury claims awards up to the amount of any unpaid balance on my account.

RECORDS RELEASE AUTHORIZATION Initial _____

You are authorized to release any information contained in my file to any insurance company, attorney, adjuster, or office staff, including any contracted billing services representing the clinic, in order to process any claim for reimbursement of charges incurred for rendered to me by you or another member of the clinic. I further authorize phone contact with the above listed third parties should phone contact be required for the purpose of obtaining payment for charges outstanding.

HIPPA/NOTICE OF INFORMATION PRACTICES Initial _____

Protecting the privacy of your personal information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

The undersigned does hereby acknowledge that he/she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and is available for public viewing in the lobby. The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation. We maintain a history of protected health information disclosures that is accessible to you. We may contact you to inform you about our practice or staff clinic changes. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any concerns about privacy, contact our office.

TEXT MESSAGES Initial _____

I consent to receiving text messages. Message and Data Rates may apply. Reply STOP to opt-out of future messaging or reply HELP for additional messaging help. Messaging frequency will vary.

Patient Signature **Patient Printed Name** **Current Date**