COON RAPIDS CHIROPRACTIC OFFICE **File#**_____

Patient Intake Information

Today's Date:_____ **Patient Title:** Mr. Mrs. Ms. Miss Dr. Prof. Rev.

First Name:_____ **MI:**_____ **Last Name:**_____ **Suffix:**_____

Nick Name:_____ **Birth Date:**_____ **SSN**_____ **Gender:** Male Female Unspecified

Address:_____

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

Primary Phone:_____ ◯ **Cell Phone:**_____ ◯ **Work Phone:**_____ ◯

Home Email:_____ ◯ **Work Email:**_____ ◯

*****Please Specify With A Check Which Above Is Your Preferred Contact Method*****

Employment Status: Employed FT Student PT Student Retired Self Employed Other

Name of Employer:_____ **Address:**_____

City:_____ **State:**_____ **Zip Code:**_____ **Phone:**_____

Marital Status: Single Married Other

Spouse/Parent/Guardian Name:_____ **Birth Date:**_____ **Phone:**_____

Referred By:_____

Race:

White Black/African American Hispanic American Indian/Alaskan Native Asian

Other:_____ I choose not to specify

Multi Racial? Yes No I choose not to specify

Ethnicity: Hispanic/Latino Not Hispanic Latino I choose not to specify

Preferred Language:

English Spanish American Sign Language French German

Korean Russian Other_____ I choose not to specify

Security/Verification Question: ***(Choose& circle <u>One</u> question you wish to answer)***

What is the name of your favorite pet? **In what city were you born?** **What high school did you attend?**

What is the name of your favorite movie? **What is your mother's maiden name?** **On what street did you grow up?**

What was the make of your first car? **When is your anniversary?** **What is your favorite color?**

Security/Verification Answer to <u>Chosen</u> Question:_____

****(Answer must be at least 6 characters long)****

Do you currently smoke tobacco of any kind? Yes Former Smoker Never been a smoker

If yes, how often do you smoke? Current every day smoker Current Sometimes smoker

If yes, what is your level of interest in quitting smoking? **1 2 3 4 5 6 7 8 9 10**

No interest **Very interested**

Current Medications include dosages if known. If you take no medications, check here _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any known allergies to medications. If you have no medication allergies, check here_____

_____ _____ _____

_____ _____ _____

Briefly list your main health problems:_____

Has any doctor diagnosed you with hypertension presently? Yes No If yes, Describe?_____

Has any doctor diagnosed you with diabetes presently? Yes No **If yes, what type?** Type 1 Type 2

If yes to diabetes, do you know what your last A1c blood work number was?_____

Have you had an X-Ray, CT or MRI Scan of your Low Back within the last 28 days? Yes No

Patient Signature:_____**Date:**_____

<u>Office Use Only</u>

Height_____ Weight_____ Blood Pressure_____

ANSWERS TO QUESTIONS OFTENS ASKED ABOUT OUR FEES AND PROCEDURES

To the New Patient:
a thorough understanding of our fees and procedures is necessary in order to maintain a good doctor/patient relationship, a factor which is very important in gaining maximum recovery. Therefore, we want you to feel free to discuss our recommendations or fees with us at any time.

Consultation:
During the consultation, the doctor will take your case history and make a preliminary examination to determine whether you should be referred elsewhere or are a chiropractic case, and if so, what further tests, examinations and x-rays are indicated. At each office visit, a brief inspection of the condition(s) will be done.

Examination:
Some conditions, such as minor strains, require only an examination and may or may not need x-rays to determine the factors causing them. The doctor will discuss this with you if you have any questions. Other conditions, more deep-seated in origin, may require more extensive examination and x-ray to disclose the various factors that may influence or contribute to the underlying cause of the condition.

Your Case Report:
When the necessary examinations are completed, the doctor will correlate and evaluate the findings. He will fully explain the diagnosis, treatment recommendations and the expected duration of treatment. Before starting treatments, he will also answer any questions you may have to help you fully understand your problem. Please inform the doctor of any new conditions or changes in your present condition that may occur for the purpose of re-evaluation.

NEW PATIENT PROCEDURES

The following information is given so you will feel comfortable and relaxed during your time here. After the initial intake forms are processed, you will be taken to the doctor's consultation room. The doctor will then visit with you and take a history of your condition. You will then be examined to determine as near as possible the extent of your problem. If the examination indicates that x-rays are necessary, you will be taken with a CA to the x-ray room for those services.

When treatment begins, it will be a gentle hands-on manipulative approach by the doctor who will try to explain the gentle moves you feel or sounds you hear. He is very willing to answer your questions about any phase of the care here or any of your health needs.

"I consent to the physical examination, x-ray studies if needed, laboratory procedures if needed, chiropractic or adjunctive therapy or other clinic service that is ordered under the general and/or specific instructions of the doctor."

_____ _____
Signature Date

MOTOR VEHICLE ACCIDENT REPORT

Name:_____ Birth Date:_____

Address:_____ SSN:_____

City:_____ State:_____ Zip:_____

Insured's Name (if not patient) _____

Address:_____City: _____ State: _____ Zip:_____

Insured's Birth Date: _____ Insured's Phone:_____

Motor Vehicle Insurance Co:_____

Agents Name:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Policy #:_____ Claim #:_____

Are you being represented by an attorney in this case? If yes,

Attorney's Name :_____ Phone:_____

Address: _____ City: _____ State: _____ Zip:_____

********** ********** ********** **********

Accident Date:_____ Time:_____ Dates off work (if any):_____

Explain in detail how the accident happened:

Describe your symptoms/injuries in detail:

Have you seen other doctors for this injury? If yes, list doctor/clinic names and dates seen:

Have you had similar pain/symptoms before? If yes, Please explain (include doctors/clinics seen, and dates):

Signature:_____ Date:_____

Coon Rapids Chiropractic Office

Name:_____ **DOB:**_____ **Date:**_____

1) Describe your symptoms:_____

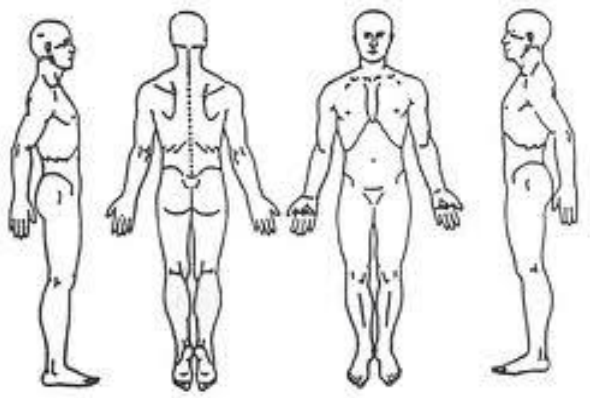
_____

When did your symptoms begin?: _____

What caused your symptoms?: _____

2) How often do you experience your symptoms? (Indicate on the drawing where you have symptoms)

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



3) What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull Ache ⑤ Burning
③ Numb ⑥ Tingling

4) How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

Indicate the average intensity of your current symptoms: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
None Unbearable

How much has your current pain interfered with your normal work (including both work outside the home and housework.)

① **Not at All** ② **A little bit** ③ **Moderately** ④ **Quite a bit** ⑤ **Extremely**

5) In general would you say your overall health right now is :

① **Excellent** ② **Very Good** ③ **Good** ④ **Fair** ⑤ **Poor**

6) Who have you seen for your symptoms? ① **No One**_____ ③ **Medical Doctor**_____

② **Chiropractor** _____ ④ **Physical Therapy/Other**_____

What treatment did you receive and when?_____

What tests have you had for your symptoms and when? X-Ray(s) Date:_____ **CT Scan Date:**_____

MRI Date:_____ **Other Date:**_____

7) Have you had similar symptoms in the past? **Yes** ○ **No** ○

If you have received treatment in the past for the same or similar symptoms, who did you see?

○ **This Office** ○ **Medical Doctor** ○ **Physical Therapist**
○ **Chiropractor** (not here) ○ **Other**_____

8) What is your occupation?

○ **Professional/Executive** ○ **Laborer** ○ **Retired**
○ **White Collar/Secretarial** ○ **Homemaker** ○ **Other**_____
○ **Trades Person** ○ **FT Student** ○ **PT Student**

9) What is your current work status?

○ **Full Time** ○ **Self Employed** ○ **Off Work**
○ **Part Time** ○ **Unemployed** ○ **Disability**

Patient Signature_____ **Date**_____

Patient Name:_____ **Date:**_____

What type of regular exercise do you perform? ○ None ○ Light ○ Moderate ○ Strenuous

For each of the conditions listed below, place a check in the "Past" or "Present" column if you have had the condition in the past, present or check both boxes if both applies.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones	○	○	Allergies
○	○	Elbow Pain/Upper Arm Pain	○	○	Kidney Disorders	○	○	Depression
○	○	Wrist Pain	○	○	Bladder Infections	○	○	Systemic Lupus
○	○	Hand Pain	○	○	Painful Urination	○	○	Epilepsy
			○	○	Loss of Bladder Control	○	○	Dermatitis/Eczema/Rash
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	HIV/AIDS
○	○	Knee/Lower Leg Pain						
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite			FEMALES ONLY
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Hormone Replacement
○	○	Arthritis	○	○	Hepatitis	○	○	Pregnancy
○	○	Rheumatoid Arthritis	○	○	Liver/Gallbladder Disorder			
○	○	General Fatigue	○	○	Cancer			Other Health Problems/Issues
○	○	Muscular Incoordination	○	○	Tumor	○	○	_____
○	○	Visual Disturbances	○	○	Asthma	○	○	_____
○	○	Dizziness	○	○	Chronic Sinusitis	○	○	_____

Please indicate if a family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus Other ○ _____

List all surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Patient Signature:_____ **Date:**_____

Neck Pain Tool

Name: _____ **Date:**_____

Total Score (0-50): _____

Circle **ONE** number in each section which most closely describes your pain.

Section 1 - Pain Intensity	**Section 6 - Concentration**
0. I have no pain. **1.** I have very mild pain. **2.** I have very moderate pain. **3.** I have fairly severe pain. **4.** I have very severe pain. **5.** I have the worst pain imaginable.	**0**. I can concentrate with no difficulty **1**. I can concentrate with slight difficulty. **2**. I can concentrate with a fair degree of difficulty. **3**. I have a lot of difficulty concentrating. **4.** I can hardly concentrate. **5**. I cannot concentrate at all.
Section 2 - Personal Care (Washing, Dressing, etc.)	**Section 7 - Work**
0. I can look after myself normally without extra pain **1**. I can look after myself normally but it causes extra pain. **2**. It is painful to look after myself and I have to be slow and careful. **3.** I need some help, but manage most of my personal care. **4.** I need help everyday in most aspects of self care. **5.** I cannot get dressed, I wash with difficulty and stay in bed.	**0**. I can do as much work as I want to do. **1.** I can only do my usual work, but no more. **2**. I can do most of my usual work, but no more. **3.** I cannot do my usual work. **4**. I can hardly do anything at all. **5.** I cannot do any work at all.
Section 3 - Lifting	**Section 8 - Driving**
0. I can lift heavy weights without extra pain. **1**. I can lift heavy weights but it causes extra pain. **2**. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned. **3**.Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. **4**. I can lift only very light weights. **5**. I cannot lift or carry anything at all.	**0**. I can drive my car without any neck pain. **1.** I can drive my car as long as I want with only slight neck pain. **2.** I can drive my car as long as I want with moderate neck pain. **3.** I cannot drive my car as long as I want because of moderate neck pain. **4.** I can hardly drive at all because of neck pain. **5**. I cannot drive my car at all.
Section 4 - Reading	**Section 9 - Sleeping**
0. I can read as much as I want with no neck pain. **1**. I can read as much as I want with slight neck pain. **2**. I can read as much as I want with moderate neck pain. **3**. I cannot read as much as I want because of moderate neck pain. **4**. I cannot hardly read at all because of fairly severe neck pain. **5**. I cannot read at all.	**0.** I have no trouble sleeping. **1**. My sleep is slightly disturbed (less than 1 hour sleeplessness). **2**. My sleep is mildly disturbed (1-2 hours sleeplessness). **3**. My sleep is moderately disturbed (2-3 hours sleeplessness). **4**. My sleep is greatly disturbed (3-5 hours sleeplessness). **5.** My sleep is completely disturbed (5-7 hours sleeplessness).
Section 5 - Headaches	**Section 10 - Recreation**
0. I have no headache at all **1**. I have slight headaches which come infrequently. **2**. I have moderate headaches moderate headaches which come frequently. **3**. I have moderate headaches which come infrequently. **4**. I have severe headaches which come infrequently. **5**. I have severe headaches which come frequently.	**0.** I am able to engage in all of my recreation activities with n o neck pain. **1.** I am able to engage in all of my recreation activities with some neck pain. **2.** I am able to engage in most, but not all of my usual recreation activities because of neck pain. **3**. I am able to engage in a few of my usual recreation activities, but not all, because of neck pain. **4**. I can hardly do any recreation activities because of neck pain. **5**. I cannot do any recreation activities at all.

Pain Severity Scale (Circle ONE)

0	1	2	3	4	5	6	7	8	9	10

No Pain **Excruciating Pain**

Low Back Pain Tool

Name: _____ **Date:**_____

Total Score (0-50): _____

Circle **ONE** number in each section which most closely describes your pain.

Section 1 - Pain Intensity	Section 6 - Standing
0. The pain comes and goes and is very mild. **1**. The pain is mild and does not vary much. **2**. The pain comes and goes and is moderate. **3**. The pain is moderate and does not vary much. **4**. The pain comes and goes and is very severe. **5.** The pain is severe and does not vary much.	**0**. I can stand as long as I want without pain. **1.** I have some pain on standing but it does not increase with time. **2**. I cannot stand longer than 1 hour without increasing pain. **3**. I cannot stand longer than 1/2 hour without increasing pain. **4.** I cannot stand longer than 10 minutes without increasing pain. **5**. I avoid standing because it increases straight away.
Section 2 - Personal Care	**Section 7 - Sleeping**
0. I would have to change my way of washing or dressing in order to avoid pain. **1**. I do not normally normal change my way of washing or dressing even though it may cause some pain. **2**. Washing and dressing increase the pain but I manage not to change my way of doing it. **3**. Washing and dressing increase the pain and I find it necessary to change my way of doing it. **4**. Because of the pain, I am unable to do some washing and dressing without help. **5.** Because of the pain, I am unable to do any washing or dressing without help.	**0**. I get no pain in bed. **1**. I get pain in bed but does not prevent me from sleeping well. **2**. Because of the pain, my normal nights sleep is reduced by less than 1/4. **3.** Because of the pain, my normal nights sleep is reduced by less than 1/2. **4**. Because of the pain, my normal nights sleep is reduced by less than 3/4. **5**. Pain prevents me from sleeping at all.
Section 3 - Lifting	**Section 8 - Social Life**
0. I can lift heavy weights without extra pain. **1**. I can lift heavy weights but it causes extra pain. **2**. Pain prevents me from lifting heavy weights off the floor, but I can manage if conveniently placed. **3.** Pain prevents me from lifting heavy weights, but can manage light to medium weights. **4**. I can only lift light weights when conveniently placed. **5**. I cannot lift at all.	**0**. My social life is normal and gives me no pain. **1**. My social life is normal, but increases the degree of pain. **2.** Pain has no significant effect on my social life apart from limiting my more energetic interests (eg. dancing, aerobics)etc. **3**. Pain has restricted my social life and I do not get out very often. **4.** I hardly have a social life due to the pain . **5.** Pain has restricted my social life to my home.
Section 4 - Walking	**Section 9 - Traveling**
0. I have no pain walking **1**. I have some pain walking that does not increase with distance. **2**. I cannot walk more than 1 mile without increasing the pain. **3**. I cannot walk more than 1/2 mile without increasing the pain. **4**. I cannot walk more than 1/4 mile without increasing the pain. **5**. I cannot walk at all without increasing the pain.	**0**. I get no pain when traveling. **1**. I get some pain when traveling, but none of my usual forms of travel make it worse. **2.** I get extra pain when traveling, but it does not compel me to seek alternative forms of travel. **3**. I get extra pain when traveling which compels me to seek alternate forms of travel. **4**. Pain restricts all forms of travel. **5**. Pain prevents me from all forms of travel except that done lying down.
Section 5 - Sitting	**Section 10 - Changing Degree of Pain**
0. I can sit in any chair as long as I like. **1**. I can only sit in my favorite chair as long as I like. **2**. Pain prevents me from sitting more than 1 hour. **3**. Pain prevents me from sitting more than 1/2 hour. **4.** Pain prevents me from sitting more than 10 minutes. **5.** I avoid sitting because it increases pain straight away.	0. My pain is rapidly getting better. 1. My pain fluctuates but overall is definitely getting better. 2. My pain seems to be getting better but improvement is slow at present. 3. My pain is neither better nor worse. 4. My pain is gradually worsening. 5. My pain is rapidly worsening.

Pain Severity Scale (Circle ONE)

0	1	2	3	4	5	6	7	8	9	10
No Pain										**Excruciating Pain**

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used at Coon Rapids Chiropractic Office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of you PHI we encourage you to read the HIPAA Notice that is available to you at the front desk before signing this consent.

1) The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance company(s) provided to us by the patient for the purpose of payment.

2) The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.

3) A patient's written consent needs only to be obtained one time for all subsequent care given to the patient in this office.

4) The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5) For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are know by this office to assure that your records are not readily available to those who do not need them.

6) Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7) If the patient refuses to sign this consent for the purpose of treatment, payment and health care options, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Patient Name (Printed) **File #**

_____ _____

Patient Signature ***(Parent/Legal Guardian signature & Relationship if applicable)*** **Date**