

NEW PATIENT INTAKE

Lachinski Chiropractic, P.A. 9580 Noble Parkway North, Brooklyn Park, MN 55443 Phone (763)561-6020 Fax (763)561-2651

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M or F _____ Marital Status: S M D _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____ Email: _____

Employer: _____ Occupation: _____

Name of Spouse: _____ Spouse's Date of Birth: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Referred to Our Office By: _____

Are Your Complaints Related to a Work Injury? Y or N _____

Are Your Complaints Related to an Auto Accident? Y or N _____

Method of Payment: Cash Insurance _____

If insurance we will take a Copy of Your Insurance Card(s)

Patient Informed Consent:

I, <print name> , the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature: _____ Date: _____

CHIROPRACTIC PATIENT HISTORY

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Location:

What Is Your Primary Complaint? _____

What Caused The Onset? _____

When Did It Start? ____ / ____ / ____

Does the Complaint Radiate or Travel? If so, Where? _____

Timing and Duration:

- ✓ Since the onset of your complaint how has it been changing? Getting Better Not Changing Getting Worse
- ✓ How often do you experience this complaint? Constantly (100%) Frequently (75%) Occasionally (50%) Intermittently (25%)
- ✓ Does your complaint worsen? If so, When? Morning Midday Night Sleep Work Other: _____
- ✓ How much has the complaint interfered with your normal work? (including both work outside the home, and housework)
 Not at all A little bit Moderately Quite a bit Extremely
- ✓ How much would you say this complaint has affected your social activities?
 All of the time Most of the time Some of the time A little of the time None of the time

Severity:

Use the key below to rate the severity of your pain.

- Mild Moderate Severe

Quality:

- ✓ How would you describe the sensation of your complaint?
 Sharp pain Shooting Numbness Tingling
 Dull Ache Burning Throbbing Other: _____

Modifying Factors:

- ✓ What makes your complaint feel worse?
 Coughing / Sneezing Standing Lifting Exercising Bending Twisting
 Pushing / Pulling Sitting Walking Driving Climbing Other: _____

Alleviating Factors:

- ✓ What makes your complaint feel better?
 Rest / Sleep Stretching Lifting Exercising Bending Twisting
 Pain Medication Ice Heat Shower Walking Other: _____

Previous Treatment:

Who have you seen for this condition? Medical Doctor Physical Therapist Chiropractor Other: _____

Have you had Chiropractic care in the past? Yes No If so, When? ____ / ____ / ____

Risk Factors:

- Do you have a pace maker? Yes No Are you pregnant? Yes No Maybe
Do you have any metal implants or devices? Yes No

History was obtained from: Patient Parent Guardian Child Other: _____

Patient / Guardian Signature: _____ Date: _____

Dr: _____

PAST AND GENERAL HISTORY

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Past History: Please Mark Below With an "X"

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition	Past	Present	Allergies
X		Example	X	X	Example		X	Example	X	X	Example
		Angina / Chest Pain			Heart Problems			Seizures			Animal Dander
		Arthritis			HIV			Sleeping Problems			Latex
		Asthma			Irritability			Soreness			Food Allergies
		Back Pain			Joint Stiffness			Speaking Problems			Penicillin
		Balance Problems			Joint Swelling			Spinal Curvature			Pollen
		Broken Bones			Joint Tenderness			Stiffness			Smoke
		Cancer			Loss of Sleep			Stroke / TIA			Grasses
		Chills			Lumps			Tingling			Sulfa Drugs
		Concentration Loss			Masses			Thyroid Problems			Dairy Products
		Diabetes			Memory Loss			Tremors			Perfumes
		Dizziness			Muscle Cramps			Vertigo			Hay
		Fatigue			Muscle Pain			Weakness			Other Please List:
		Fainting			Nervousness			Other Please List:			
		Fever			Night Sweats						
		Gout			Numbness						
		Headaches			Paralysis						

Medication and Surgical History:

Surgery	Yes	No	Year	Surgery	Yes	No	Year	Have You Ever Taken:	Yes	No	Year
Tonsils				Women				Insulin			
Colon				Breast				Cortisone			
Hernia				Uterus				Thyroid Medication			
Appendix				Ovaries				Male / Female Hormones			
Gall Bladder								Blood Pressure Medication			
Stomach				Men				Cholesterol Medication			
Heart				Prostate				Anti-Depressants			
Kidney								Tranquilizers / Sedatives			
								Birth Control			

What Other Supplements, Vitamins or Medications Are You Taking? _____

Injury History:

What, If Any, Major Injuries Have You Had? When? _____

Have You Been Hospitalized? If so, When and Why? _____

Patient / Guardian Signature: _____ Date: _____

Dr: _____

SOCIAL AND FAMILY HISTORY

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Social History:

- ✓ **What Is The Highest Level of Schooling You Have Completed?**
 Still in School Some High School High School Some College College Graduate School
- ✓ **What Is Your Current Work Status?**
 Employed Full Time Employed Part Time Retired Unemployed Disabled Student
- ✓ **How Often Do You Exercise?**
 Never 1-3 times per month 1-2 times per week 3-4 times per week daily
- ✓ **How Would You Rate The Intensity Of Your Exercise?**
 Never Exercise Low Level Moderate Level High Level Competition level
- ✓ **How Many Hours Do You Sleep Per Night?**
 <4 hours 5-6 hours 7-8 hours 8-10 hours >10 hours
- ✓ **How Often Do You Eat A Balanced Diet?**
 Never Rarely Sometimes Regularly Always
- ✓ **How Often Do You Drink Caffeinated Beverages?**
 Never 1-3 Times Per Month 1-2 Times Per Week 3-4 Times Per Week Daily >2 Per Day
- ✓ **How Often Do You Smoke Cigarettes?**
 Never Past 1-3 packs per month 1-2 packs per week 3-4 packs per week >1 pack per day
- ✓ **How Often Do You Drink Alcohol?**
 Never Past 1-3 drinks per month 1-2 drinks per week 3-4 drinks per week daily
- ✓ **Have You Used Illicit / Street Drugs In The Past 6 Months?**
 Yes No

Daily Activities:

So that we may have an idea as to your daily routine please list a few of your daily activities and your favorite hobbies:

- ✓ **Does Your Current Condition Affect Your Performance In These Activities Or Hobbies?**

Yes No If So How: _____

Family History Information:

- ✓ **Please Indicate If Anyone In Your Family Currently Has, Or Has In The Past, Suffered From Any Of The Conditions Listed Below:**

✓ **Arthritis:**
 Yes No Whom: _____

✓ **High Blood Pressure:**
 Yes No Whom: _____

✓ **Back Pain:**
 Yes No Whom: _____

✓ **High Cholesterol:**
 Yes No Whom: _____

✓ **Cancer:**
 Yes No Whom: _____

✓ **Osteoporosis:**
 Yes No Whom: _____

✓ **Diabetes:**
 Yes No Whom: _____

✓ **Stroke:**
 Yes No Whom: _____

✓ **Heart Disease:**
 Yes No Whom: _____

✓ **Thyroid Conditions:**
 Yes No Whom: _____

Patient / Guardian Signature: _____ Date: _____

Dr: _____

ASSIGNMENT OF BENEFITS/ PATIENTS AUTHORIZATION FORM

Lachinski Chiropractic, P.A. 9580 Noble Parkway North, Brooklyn Park, MN 55443 Phone (763)561-6020 Fax (763)561-2651

- As a courtesy to you, we will complete and submit all necessary claim forms to your insurance company; however, it is important to understand that you are ultimately responsible for payment of any and all charges incurred by you during your treatment.
- I hereby authorize and direct you, my insurance company, and/or my attorney to pay directly to Lachinski Chiropractic, P.A., for all charges incurred in the clinic during my course of treatment. I also authorize the release of any information required to process all valid insurance claims filed on my behalf.

Patient / Guardian Signature: _____ **Date:** _____

Patient Consent Form

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-rays, and physical therapy techniques, on me.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts he knows, are in my best interest.

I will exercise my right to discuss with the doctor the nature, purpose and risks of chiropractic adjustments and other recommended procedures in order to have all my questions answered to my satisfaction prior to treatment. I further understand that the results are not guaranteed.

By signing below, I state that I have decided it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) of which I seek treatment.

Patient / Guardian Signature: _____ **Date:** _____

HIPPA NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have the right to receive and review and agree to the notice of privacy practices of Lachinski Chiropractic, P.A. which describes the Practice's policies and procedures regarding the use and disclosure of any of my protected health information created, received, or maintained by Lachinski Chiropractic, P.A.

Patient / Guardian Signature: _____ **Date:** _____

AUTHORIZATION FOR TREATMENT OF A MINOR

I hereby authorize Lachinski Chiropractic, P.A. to provide treatment for my child.

Child's Name _____

Patient / Guardian Signature: _____ **Date:** _____