Lake Marion Chiropractic Center
9202 202nd St W, Suite 203
Lakeville, MN 55044
952-469-8385

Patient Health History

Today's Date / / **Signature of Patient** _____

Patient Title: *(check one)* ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr. ❑ Prof. ❑ Rev.

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____**Suffix** _____

Address 1 _____

Address 2 _____

City_____ **State**_____ **Zip Code** _____

Primary Phone _____**Secondary Phone** _____

Mobile Phone _____

Home email _____ **Work Email** _____

Which email address would you like us to use to communicate with you? *(check one)* ❑ Home ❑ Work

Contact Method *(check one)*

❑ Primary Phone ❑ Secondary Phone ❑ Mobile Phone ❑ Home Email ❑ Work Email

Date of Birth / / **Age** _____ **Gender** *(check one)* ❑ Male ❑ Female

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **SSN** _____

Employment Status *(check one)*

❑ Employed ❑ FT Student ❑ PT Student ❑ Other ❑ Retired ❑ Self Employed

Race *(check one)*

❑ White	❑ Black/African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian or other Pacific Island
❑Samoan	❑ Guamanian or Chamorro	❑Other_____	❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language ***(check one)***

❑ English	**❑ Spanish**	**❑ American Sign Language**	**❑ Chinese**	**❑ French**	**❑ German**
❑ Tagalong	**❑ Vietnamese**	**❑ Italian**	**❑ Korean**	**❑ Russian**	**❑ Polish**
❑ Arabic	**❑ Portuguese**	**❑ Japanese**	**❑ French Creole**	**❑ Greek**	**❑ Hindi**
❑ Persian	**❑ Urdu**	**❑ Gujarati**	**❑ Armenian**	**❑ I choose not to specify**	

How were you referred to our office?

_____

Family Medical Doctor:

_____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

Please check any and all insurance coverage that may be applicable in this case:

___ Major Medical ___Worker's Compensation ___Medicaid ___Medicare ___Auto Accident

___Medical Savings Account & Flex Plans ___Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Verification Question ***(choose only one question by circling the question, then give the answer to that question)***

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

Verification Answer to the Chosen question: _____

(answer must be at least 6 characters in length)

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?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No interest ***Very Interested***

Current medications, including dosage and reason for taking medication.
If there are no current medications, check here: ❑

1)_____ **Dosage**_____ **Reason**_____

2)_____ **Dosage**_____ **Reason**_____

3)_____ **Dosage**_____ **Reason**_____

4)_____ **Dosage**_____ **Reason**_____

List any known allergies you have had to any *medications* and the reaction.
If no allergies are known, check here: ❑

1) _____ **Reaction** _____

2) _____ **Reaction** _____

3)_____ **Reaction** _____

List any known allergies of any kind and the reactions.

If no allergies are known, check here: ❑

1) _____ **Reaction** _____

2) _____ **Reaction** _____

3) _____ **Reaction** _____

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 kind? ❑ Type I ❑ Type II

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? **❑ Yes ❑ No ❑ Not Sure**

If yes, other comments regarding Diabetes: _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ❑ Yes ❑ No

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto___ Work____ Other_____**?**

Have you ever had the same or a similar condition? π **Yes** π **No**

If yes, when and describe:

_____

Days lost from work: _____ **Date of last physical examination:** _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates):

_____

_____

Have you been treated for any health condition by a physician in the last year? π **Yes** π **No**

If yes, describe: _____

To be performed by clinic staff:

Height: _____inches **Weight:** _____ pounds **BP:** _____ / _____

Women: Are you pregnant? _____

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter N if you have these conditions now or P if you have had these conditions previously.

N = Now **P = Previously**

Headaches_____ **Frequency** _____		**Loss of Balance**	_____
Neck Pain	_____	**Fainting**	_____
Stiff Neck	_____	**Loss of Smell**	_____
Sleeping Problems	_____	**Loss of Taste**	_____
Back Pain	_____	**Unusual Bowel Patterns**	_____
Nervousness	_____	**Feet Cold**	_____
Tension	_____	**Hands Cold**	_____
Irritability	_____	**Arthritis**	_____
Chest Pains/Tightness	_____	**Muscle Spasms**	_____
Dizziness	_____	**Frequent Colds**	_____
Shoulder/Neck/Arm Pain	_____	**Fever**	_____
Numbness in Fingers	_____	**Sinus Problems**	_____
Numbness in Toes	_____	**Diabetes**	_____
High Blood Pressure	_____	**Indigestion Problems**	_____
Difficulty Urinating	_____	**Joint Pain/Swelling**	_____

Weakness in Extremities	_____	**Menstrual Difficulties**	_____
Breathing Problems	_____	**Weight Loss/Gain**	_____
Fatigue	_____	**Depression**	_____
Lights Bother Eyes	_____	**Loss of Memory**	_____
Ears Ring	_____	**Buzzing in Ears**	_____
Broken Bones/Fracture	_____	**Circulation Problems**	_____
Rheumatoid Arthritis	_____	**Seizures/Epilepsy**	_____
Excessive Bleeding	_____	**Low Blood Pressure**	_____
Osteoarthritis	_____	**Osteoporosis**	_____
Pacemaker	_____	**Heart Disease**	_____
Stroke	_____	**Cancer**	_____
Ruptures	_____	**Coughing Blood**	_____
Eating Disorder	_____	**Alcoholism**	_____
Drug Addiction	_____	**HIV Positive**	_____
Gall Bladder Problems	_____		
Ulcers	_____		

SOCIAL HISTORY

Alcohol Consumption	_____	**Coffee Consumption**	_____
Water Consumption	_____	**Soda Consumption**	_____
Pain Reliever Frequency	_____	**Recreational Drug Use**	_____
Exercise Frequency	_____	**Amount of Sleep**	_____

Healthy Eating Rank	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Physical Stress	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Emotional Stress	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Health Goals

_____

_____

_____

_____

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

CONSULTATION QUESTIONNAIRE

1. What is your major symptom? _____
2. What does this prevent you from doing or enjoying?_____
3. If this is a recurrence, when was the first time you noticed this problem?_____
   How did it originally occur?_____
   Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse _____
   If yes, when and how? _____
4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only ___
   How long does it last? All Day _____ Few Hours _____ Minutes _____
5. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes _____ No _____. If yes, describe: _____
   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____
   _____
6. Describe the pain: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____
   Burning _____ Stabbing _____ Other _____
7. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____
   _____. If no, what have you tried to do that has not helped? _____
   _____
8. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____
   Lifting _____ Twisting _____ Other _____
9. List any major accidents you have had other than those that might be mentioned above: _____
   _____
10. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
    Yes _____ No _____ Uncertain _____
11. Remarks: _____
    _____
    _____

NO SYMPTOMS ——— EXTREME SYMPTOMS

Please place an “X” on the line above to indicate level of problem.

Doctor’s Signature _____ Date _____