Dynamic Family Chiropractic

4739 Hwy 101 S. * Minnetonka, MN 55345* 952.933.2695 * Fax 952.933.2763

Date: _____

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____ Age: _____ Gender: M F

Home Address: _____ Home Phone: ( ) _____

City, State, Zip: _____ Work Phone: ( ) _____

Email Address: _____ Cell Phone: ( ) _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Work Phone: ( )_____ Cell Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint: _____

Is this purpose related to an auto accident / work injury? ☐ Yes ☐ No If so, when: _____

When did this condition begin? _____/_____/_____ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? _____

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No Describe: _____

Type of pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

Does the pain radiate into your: ___Arm ___Leg ___Does not radiate Is this condition getting worse? ☐ Yes ☐ No

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with activity

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: _____

Have you experienced this condition before? ☐ Yes ☐ No If so, please explain: _____

Who have you seen for this? _____ What did they do? _____

How did you respond? _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a chiropractor before? ☐ Yes ☐ No Who? _____ When? _____

Reason for visits: _____

How did you respond? _____

Did your previous chiropractor take before and after x-rays? ☐ Yes ☐ No

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: _____

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much / week? _____

Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

HEALTH CONDITIONS

CERVICAL SPINE (NECK):

Postural distortions from subluxations (misalignments of the spine) in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience…?

- ❑ Neck Pain
- ❑ Pain into your shoulders/arms/hands
- ❑ Numbness/tingling in arms/hands
- ❑ Hearing disturbances
- ❑ Weakness in grip
- ❑ Headaches
- ❑ Dizziness
- ❑ Visual disturbances
- ❑ Coldness in hands
- ❑ Thyroid conditions
- ❑ Sinusitis
- ❑ Allergies/Hay fever
- ❑ Recurrent colds/Flue
- ❑ Low Energy/Fatigue
- ❑ TMJ/Pain/Clicking

THORACIC SPINE (UPPER BACK):

Postural distortions from subluxations in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience…?

- ❑ Heart Problems
- ❑ Recurrent Lung Infections/Bronchitis
- ❑ Asthma/Wheezing
- ❑ Shortness Of Breath
- ❑ Pain On Deep Inspiration/Expiration

THOPRACIC SPINE (MID BACK):

Postural distortions from subluxations in the mid back will weaken the nerves into your ribs/chest and upper digestive tract, and affect these parts of your body. Do you experience…?

- ❑ Mid Back Pain
- ❑ Pain Into Your Ribs/Chest
- ❑ Indigestion/Heartburn
- ❑ Reflux
- ❑ Nausea
- ❑ Ulcers/Gastritis
- ❑ Blood Sugar problems

LUMBAR SPINE (LOW BACK):

Postural distortions from subluxations in the low back will weaken the nerves into your legs/feet and pelvic organs and affect these parts of your body. Do you experience…?

- ❑ Pain into your hips/legs/feet
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in your legs/feet
- ❑ Muscle cramps in your legs/feet
- ❑ Constipation / Diarrhea
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Recurrent bladder infections
- ❑ Frequent/difficulty urinating
- ❑ Menstrual irregularities/cramping (females)
- ❑ Sexual dysfunction
- ❑ Low back pain

Please list any health conditions not mentioned: _____

Please list any medications currently taking and their purpose : _____

Please list all past surgeries: _____

Please list all previous accidents and falls: _____

GOALS FOR MY CARE

Indicate all statements that apply to you:

❑ I have a specific health concern which I would like relief from.

❑ I want to ensure that my health concerns do not become an ongoing problem.

❑ I am interested in learning more about how chiropractic can help my overall health.

Please indicate what services you are interested in:

❑ I am interested in chiropractic care.

❑ I am interested in nutritional consultation and supplementation.

❑ I am interested in back strengthening and exercise routines.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised the x-ray can be hazardous to an unborn child.

Date of the last menstrual cycle: _____

_____ Signature

_____ Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment. You have the right as a patient to be informed about the condition of your health and recommended care and treatment to be proved so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be preformed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me and to my satisfaction.

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health 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 purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures
- You may inspect and receive copies of your records for a fee within 14 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and it's staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.
I have read and fully understand the above statements regarding the Terms of Acceptance and your Notice of Privacy Practices and therefore accept chiropractic care on this basis.

_____ _____

Print Name Date

_____

Signature