

Welcome to Dakota Ridge Chiropractic

File # _____

To ensure your visit with us is a pleasant one, here are the procedures you can expect during the next 60 minutes

- PAPERWORK** Complete this brief questionnaire and your health history form to help us get to know you. The Doctor will use this information to help formulate the recommendations for your care.
- CONSULTATION** The Doctor will review your history and determine if yours is a chiropractic case. You will be informed of the cost of any office procedures before they are performed.
- EXAMINATION** Standard physical, orthopedic, neurological and chiropractic tests will be performed to determine the cause(s) of your subluxation.
- SPINAL IMAGES** Necessary views may be taken to visualize the location of any spinal problems, neurological interferences, reveal any pathologies and make your chiropractic care more precise.
- CORRELATION** Before proper care can be rendered, the Doctor will study your examination findings. Later you will see x-rays, review your findings and receive specific care and recommendations from the Doctor.
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CONFIDENTIAL PATIENT CASE HISTORY - GENERAL INFORMATION

DATE _____

Miss Mrs. Ms. Mr. How would you like to be addressed? _____

NAME _____ SOCIAL SECURITY # _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ ext. _____

CELL PHONE _____ EMAIL _____

DATE of BIRTH _____ AGE _____ SEX M F

Occupation or Profession _____ Employer _____

Marital Status: Single Married Divorced Widowed Spouse/Partner's Name _____

Number of Children _____ Names and Ages _____

Primary Care Physician _____ Office _____ Phone _____

Insurance Coverage? Yes No Company _____

Insured's Name _____ Relation: Self Spouse Parent/Guardian Other

Address _____

ID/Subscriber # _____ Group # _____

IN THE EVENT OF AN EMERGENCY:

Who should we contact? _____ Relation _____

Home Phone _____ Other Phone _____

How did you hear about us? _____

CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your health record.

What is your major complaint for which you are seeking chiropractic care? _____

Is this injury related to: Work Auto Accident Sports Other Trauma Chronic Other _____

When did this condition begin? _____

What do you think caused this condition? _____

Have you had similar conditions in the past? Yes No

Is this condition getting worse? Yes No Constant Comes and Goes

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition interfering with your: Work Sleep Daily Routine Other _____

List any other doctors or therapists who have treated this condition _____

Are you currently taking any prescription medication? _____

Supplements? _____

Please list all allergies _____

What are your *other* most pressing health problems?

Please list in order of concern. (low back pain, diet/nutrition, Hypertension, diabetes, overall health, etc.)

1. _____ 2. _____ 3. _____ 4. _____

What are your goals for care? List in order of importance.

1. _____ 2. _____ 3. _____ 4. _____

How much change are you willing to make at this time to improve your health?

25% 50% 75% 100%

Do you use tobacco? Yes No If yes how much per week? _____

Do you drink alcohol? Yes No If yes how much per week? _____

Do you get regular exercise Yes No How many days per week? _____

How many hours of sleep do you get each night? _____

Please rate your stress level as it pertains to work, family life, career, etc. (1 = low stress, 10 = high stress) _____

Do you have a family history of cancer, cardiovascular disease, arthritis, diabetes? _____

Are you wearing Heel Lifts Arch Supports Custom Orthotics None

Would you be interested in being fit for a pair of custom made orthotics? Yes No

Would you be interested in a nutritional evaluation and recommendations? Yes No

Would you be interested in receiving a monthly health information newsletter by email? Yes No

(Your information will never be shared) Email address _____

Is there any other health condition, topic or product you would like more information about? _____

Do you have any family members or friends that would benefit from a check-up to evaluate the health of their spine and nervous system? _____

Patient Signature _____ 

Date _____

About Your Health...

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system, that have resulted in your lowered state of health. At your report of findings, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

PRESENT HEALTH: Are you presently affected by any of the following? (within past 3 months)
If you do not experience a particular symptom please leave blank.

O - OCCASIONAL F - FREQUENT C - CONSTANT

MUSCLE AND JOINT	O	F	C	GENERAL SYMPTOMS	O	F	C	GASTROINTESTINAL	O	F	C	CARDIOVASCULAR	O	F	C
Backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever/Chills/Sweat ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult digestion ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart beat ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful tailbone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea or vomiting .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over stomach ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous heart attack	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Faulty posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
								Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any other heart problems (murmur, valve prolapse)			
								Bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

STRESS SYMPTOMS

Headache/Migraine.

Dizziness

Numbness or pins & needles in arms/hands, legs/feet

Ringing in ears

Blurring of vision ...

Loss of sleep

Loss of concentration/memory

Irritable/Nervousness

Depression

Decreased energy/fatigue

Tension

RESPIRATORY

Chronic cough

Spitting up phlegm/blood

Chest pain

Difficult breathing ...

URINARY

Painful urination ...

Getting up at night to urinate

Blood in urine

Increased urination Yes No

EYES, EARS, NOSE, THROAT

Deafness

Earache

Sore throat

Asthma

Tonsillitis

Sinus trouble

FEMALES ONLY

Painful menstruation Yes No

Excessive flow Yes No

Irregular Yes No

Cramps or backache . Yes No

Abnormal discharge . Yes No

Passed menopause . Yes No

Are you pregnant ... Yes No

Birth control pill ... Yes No

No. of miscarriages _____
Date of last menstrual period _____

PAST HEALTH: Have you ever suffered from any of the following conditions?

	YES	NO		YES	NO		YES	NO		YES	NO
Thyroid trouble	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Emotional problems .	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Epileptic seizures ...	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure ..	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>

Please list any significant illness, operations, accidents, falls or traumas

Date	Illness /Operation /Accident /Falls

Patient Signature _____



Date _____

Dakota Ridge Chiropractic

Responsibility for Payment of Fees

Payment to be made to Dakota Ridge Chiropractic

I fully understand and agree that I am directly and fully responsible to pay in full for all professional services and/or products provided to me and/or my dependents at the time of service. I also understand and agree that such payment is not contingent upon any settlement, claim, judgment or verdict by which I may eventually recover said fee.

***** Health Insurance Patients.***** Dakota Ridge Chiropractic will make every effort to verify benefits and bill your health insurance. However, I fully understand that it is the patient's (+/or guardian's) responsibility to verify their individual coverage, and that Dakota Ridge Chiropractic will not be held liable for any misinformation given by the insurance company. It is strongly recommended that you refer to your policy brochure and/or contact your health insurer to determine your **coverage for chiropractic care**.

I also agree to pay all reasonable costs of collection, attorney fees and interest at the ANNUAL PERCENTAGE RATE of 21% (1.75% per month) on any PAST DUE BALANCE (over 60 days old).

Patient/Guardian

Relationship to Patient

Date

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health staff to perform the necessary services I need.

Specific Risks Possibilities with Chiropractic Care:

Soreness—Chiropractic adjustments and procedures are sometimes accompanied by post-treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While it is generally not dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury—Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury—Manual adjustments to the thoracic region, in rare cases, may cause rib injury or fracture. Treatment is performed carefully to minimize risk.

Stroke—Stroke is extremely rare, but is the most serious complication associated with chiropractic care. Studies estimate there is only a 1 in 5.85 million risk of stroke following an upper cervical adjustment and that the risk is no greater than a regular office visit to a family physician. (Canadian Medical Association Journal 2001) Chiropractic continues to be considered to be one of the safest forms of healthcare.

If you have any questions about this form, please ask your doctor.

I hereby give my informed consent to have chiropractic treatment administered.

Signature of Patient/Guardian

Date

Dakota Ridge Chiropractic, P.C.
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Name of Individual] consent to Dakota Ridge Chiropractic's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

X _____
Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority