D Y N A M I C

CHIROPRACTIC & NATURAL MEDICINE

250 2nd Avenue South, Suite #286
Minneapolis, MN 55401
Phone: (612) 315-4647 Fax: (612) 315-4647

Please take some time to complete this questionnaire. The questions in this questionnaire are comprehensive for overall health and wellness. We need this information in order to provide complete and total care. We look forward to working with you and are privileged to help you achieve your health and wellness goals.

CONFIDENTIAL PATIENT INFORMATION

Date _____/_____/_____

Name_____
First **Middle** **Last**

Date of Birth_____/_____/_____ Age_____ Social Security #_____-_____-_____

Address: _____

City: _____ State: _____Zip Code: _____

Home phone:_____Cell phone:_____

Work phone:_____Email Address_____

(Please, circle above the preferred method of contact for appointments, follow-up communication and other messages)

Do you wish to receive our health emails? Yes / No

Occupation: _____ Employer: _____

Marital status (circle one) Single Married Widowed Divorced

Spouse's Name:_____

Primary Care Physician_____

How did you find us and/or who may we thank for referring you?

_____

In Case of Emergency Contact

Name: _____ Relationship: _____

Phone number(s):_____

Comprehensive Health History

What are your top five chief complaints? 1._____

2. _____3._____

4._____5._____

When did your symptoms appear? _____

Is this condition due to an accident? Yes / No If so, date of accident:_____

What type of accident? Auto_____ Work_____ Home_____ Other_____

Is this condition: Improved_____ Unchanged_____ Getting Worse_____

Please give a brief history of this condition:_____

_____

Have you had similar conditions in the past? Please explain:_____

_____

*Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain)_____

*Type of pain:

Sharp_____ Dull_____ Throbbing_____

Numbness_____Aching_____Shooting_____

Tingling_____Cramps_____Stiffness_____

Swelling_____Other_____

*How often do you have this pain?_____

_____

*Is it constant or does it come and go?_____

_____

*Does this pain interfere with your:

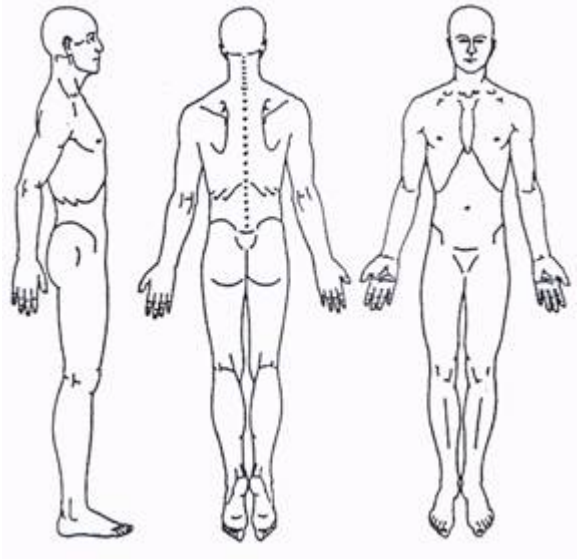
Work____Sleep____Daily Routine____Recreation____

*Activities or movements that are difficult to perform:

Sitting_____ Standing_____Walking_____

Bending_____ Lying Down_____

Please mark an **X** on the picture where you continue to have pain, numbness, tingling, or areas on your skin that have changed color or texture (e.g. moles, rashes, etc.)



What types of therapy have you tried for this problem(s)? Diet modification_____ Fasting____

Vitamins/minerals_____ herbs_____ homeopathy_____ chiropractic_____ Acupuncture_____

conventional drugs_____ other_____

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

_____

Have you ever been under Chiropractic Care? Yes / No

What was the nature of your Chiropractic Treatment? _____

List current health problems for which you are being treated:_____

_____

Current medications (prescription or over-the-counter):_____

_____

Date of last physical exam: _____

Have you had any of the following taken? MRI____ X-rays____ CT Scans____

If yes, date and where? _____

Have you had any of the following tests done?

Blood____ Urine____ Bone scan____ Other: _____

If yes, most recent date and where:_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems):

_____

Do you consider yourself: Underweight_____Overwieght_____Just right_____

Your weight today_____

Is your job associated with potentially harmful chemicals (e.g. pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g. fireman, farmer, miner)?_____

_____

Do you wear any of the following? Corrective lenses_____ Dentures_____ Hearing aids_____

Medical devices/prosthetics/implants_____

Please circle yes to any of the following health conditions that allow to you:

AIDS/HIV----------Yes / No
Anemia----------Yes / No
Anxiety----------Yes / No
Arthritis, Rheumatism-------Yes / No
Artificial Joints----------Yes / No
Athletes Foot----------Yes / No
Asthma----------Yes / No
Autoimmune Disease--------Yes / No
Back Problems----------Yes / No
Bleeding abnormally---------Yes / No
Blurred Vision----------Yes / No
Blood Disease----------Yes / No
Blood in Stool----------Yes / No
Bronchitis----------Yes / No
Cancer----------Yes / No
Canker Sores----------Yes / No
Cataracts----------Yes / No
Chemical Dependency-------Yes / No
Chemotherapy----------Yes / No
Cold Sores----------Yes / No
Cravings----------Yes / No
Crohn's Disease----------Yes / No
Circulatory Problems--------Yes / No
Congenital Heart Lesions----Yes / No
Cortisone Treatments--------Yes / No
Cough, persistent/bloody----Yes / No
Diabetes Type 1----------Yes / No
Diabetes Type 2----------Yes / No
Depression----------Yes / No
Ear Infections----------Yes / No
Easy Bruising----------Yes / No
Emphysema----------Yes / No
Epilepsy----------Yes / No
Fatigue----------Yes / No
Fainting or Dizziness---------Yes / No
Gallbladder Disease----------Yes / No

Glaucoma----------Yes / No
Growth on Head/Neck-------Yes / No
Hay Fever, Hives----------Yes / No
Heart Murmur----------Yes / No
Headaches----------Yes / No
Heart Disease----------Yes / No
Heart Problems----------Yes / No
Hemorrhoids----------Yes / No
Hepatitis Type____---------Yes / No
High Blood Pressure--------Yes / No
High Cholesterol----------Yes / No
Hyperthyroid----------Yes / No
Hypothyroid----------Yes / No
Irregular Heartbeat---------Yes / No
Immune Deficiency---------Yes / No
Jaundice----------Yes / No
Jaw Pain----------Yes / No
Kidney Disease----------Yes / No
Kidney Stone----------Yes / No
Liver Disease----------Yes / No
Low Blood Pressure---------Yes / No
Mental Illness----------Yes / No
Mitral Valve Prolapse-------Yes / No
Mood Swings----------Yes / No
Nervous Problems----------Yes / No
Night Sweats----------Yes / No
Pacemaker----------Yes / No
Poor Digestion----------Yes / No
PMS----------Yes / No
Pneumonia----------Yes / No
Psychiatric Care---------- Yes / No
Respiratory Disease--------Yes / No
Rheumatic Fever----------Yes / No
Scarlet Fever----------Yes / No
Shortness of Breath--------Yes / No
Sinus Trouble----------Yes / No
Skin Rash----------Yes / No
Sleep Problems----------Yes / No
Special Diet----------Yes / No
Strep Throat----------Yes / No

Stroke----------Yes / No
Swelling----------Yes / No
Swollen Feet/Ankles--------Yes / No
Swollen Neck Glands-------Yes / No
Thyroid Problems----------Yes / No
Tonsillitis----------Yes / No
Tuberculosis----------Yes / No
Tumor----------Yes / No
Radiation Treatment--------Yes / No
Ulcer----------Yes / No
Urinary Tract Infection------Yes / No
Venereal Disease----------Yes / No
Warts----------Yes / No
Weight Loss, unexplained---Yes / No

WOMEN:

Are you pregnant?----------Yes / No
If yes, when is your due date?_____
Are you nursing?----------Yes / No
Are you taking birth control pills?---
----------Yes / No
Irregular Periods----------Yes / No

Childhood Illnesses:

Cancer----------Yes / No
Chickenpox----------Yes / No
Diabetes----------Yes / No
Ear infection----------Yes / No
Fever----------Yes / No
Measles----------Yes / No
Mumps----------Yes / No
Poison Ivy----------Yes / No
Rheumatic----------Yes / No
Scarlet Fever----------Yes / No
Tuberculosis----------Yes / No
Scarlet Fever----------Yes / No
Strep Throat----------Yes / No
Urinary Tract Infection--------Yes / No

Medications:

List any medications you are currently taking, the correlating diagnosis, and the current dose.

Medication	Diagnosis	Dose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy Name:_____Phone:_____

Allergies:

Do you have any known allergies to foods, medication, etc? Yes / No If yes, please list and the type of reaction you get:

_____

_____

Do you consume alcohol? Yes / No If yes, how frequent? _____

Are you a smoker? Yes / No If yes, how frequent?_____

What is your personal definition of Optimal Health and Wellness?

_____

_____

In terms of your health, what goal(s) do you wish to achieve by coming to our clinic for treatment?

_____

_____

I understand and agree that all services rendered to me at Dynamic Chiropractic & Natural Medicine are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature or Guardian's Signature Authorizing Care:

_____

Date Signed: _____

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Notice of Privacy Practices

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), Public law 104-191, published December 28, 2000, by the U.S. Department of Health and Human Services, we are required to notify you of our use of your Protected Health Information (PHI).

This law allows this clinic to collect and use PHI from you for the use of health care purposes only. **"Health care purposes only" refers to normal release of practitioner's notes and/or examination findings to insurance companies authorized to reimburse this clinic for incurred charges by the patient named below or signed by their representative as stated below.** This clinic will ensure that health information is not used for non-health purposes. PHI will be disclosed only for the purpose of health care treatment, payment and operations as allowed by HIPPA. Any non-routine disclosure of your PHI will be prohibited without a signed, informed consent by yourself agreeing to such disclosure.

By signing below, I understand my rights under HIPPA and authorize the release of my PHI for routine care treatment, payment and operations. I understand I have the right to inspect, get copies, and requests amendments be made to my file at any time. I also have the right to request to receive information from this clinic by alternative means. Any non-routine disclosures must be authorized by myself by a signed consent. I understand that I have the right to complain to this clinic's Privacy Officer or to file a formal complaint to the Secretary of the Department of Health & Human Services if I feel my PHI rights have been violated. I understand that these privacy policies may change in the future.

Patient's Printed Name

_____

Patient's or Guardian's Signature **Date Signed:**

_____ _____

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Financial Policy

I, _____ understand the following:

I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment of all services and products. I understand that payment is due at the time of service in the form of cash, check, or credit card.

I understand that I am responsible for payment of any laboratory services that are prescribed for me by the doctor at the time the kit is received. I further understand that if I return a prepaid laboratory test kit for a refund of moneys, there will be a $50.00 administrative processing fee. In addition, I understand that there will be no return of funds if I choose to return prepaid laboratory test kits after 90 days from the date of purchase.

If I am prescribed nutritional supplementation and elect to purchase these products I understand that I cannot return for refund **a.)** any nutritional supplement or product that has been opened or that has broken the manufacturer's safety seal; **b.)** any refrigerated item at any time; or **c.)** any nutritional supplement or product after 90 days from the date of purchase. A 15% restocking fee may be charged for returned products.

I hereby authorize the doctor to treat my condition(s). The doctor will not be held responsible for any pre-existing medically diagnosed condition (by another doctor), or any previous medical diagnosis. I understand that I am responsible for addressing reimbursement with my insurance carrier directly should I choose to do so. I understand that this office will prepare a walk out receipt with the necessary information to assist me in making collection from my major medical insurance carrier.

Patient's or Guardian's Signature **Date Signed:**

_____ _____

Cancellation Policy

If you need to cancel or reschedule your appointment, please give us at least 12 hours notice prior to your appointment time. This is a courtesy and will enable us to accommodate other patients. There will be a 50% service fee charged to the client if a cancellation call does not take place on the first occurrence and 100% service fee thereafter.

Patient's Printed Name

_____

Patient's or Guardian's Signature **Date Signed:**

_____ _____

Thank you for your cooperation. We appreciate your business.