Marty Chiropractic

Patient Information

DATE _____

DOCTOR _____

Full Name _____ Date of Birth _____ Cell Phone _____

Address _____ Home Phone _____

City, State _____ Zip _____-_____ Work Phone _____

Occupation _____ Employer _____ Work Phone _____

May we leave messages at Home Phone YES NO May we leave messages at Work Phone? YES NO

I have been notified that there is some level of risk that protected health information transmitted by unencrypted email or text could be read by someone other than me.

I give Marty Chiropractic permission to communicate with me by:

Unencrypted Email: NO YES Email Address: _____ **Text Messages:** NO YES

Primary Physician _____ May we contact your physician? _____

Primary Clinic _____ Emergency Contact _____ Phone _____

Insurance Company: _____ Policy Holder _____ Date of Birth _____

Work Comp Injury: HR Contact Person: _____ Phone Number _____

Please let us know how you heard about our clinic! Circle answer and put appropriate name in blank provided:

Family Member ***Friend*** ***Co-worker*** ***Insurance website*** ***Internet browsing*** ***Any Health Care Provider***

Attorney ***Other:*** _____ ***Name of above referral:*** _____

AGREEMENT TO PAY FOR TREATMENT: The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to patient which is not considered to be a covered service by third party insurers or payors, such as massages, orthotics or supplements.

ASSIGNMENT OF INSURANCE: I hereby authorize and instruct the insurance company mentioned above to pay any insurance benefits otherwise payable to me under my current insurance policy directly to MARTY CHIROPRACTIC, 2424 East 117th Street, Burnsville, MN 55337, for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay any balance of said professional service charges over and above this insurance payment according to the financial policy of the above assignee, which may include interest, service fees and/or collections costs. I understand that my signature on this document may replace the need for my signature on each claim form. A photo copy of this assignment shall be considered as effective and valid as the original.

RELEASE OF MEDICAL INFORMATION: I also authorize the release of any information concerning my medical history, diagnosis, and treatment pertinent to my case to any insurance company, adjuster, or attorney involved in this case. THIS AUTHORIZATION AND ASSIGNMENT SHALL BE IRREVOCABLE FOR THE FULL EXTENT OF MY TREATMENT AT MARTY CHIROPRACTIC CLINIC AND UNTIL SUCH TIME THAT ANY AND ALL EXPENSES INCURRED HAVE BEEN PAID IN FULL.

I UNDERSTAND that I am authorizing Marty Chiropractic to proceed with any treatment that may be necessary. Furthermore, any risks involving chiropractic treatment will be explained to me upon request.

PERMISSION TO TREAT MINOR: I hereby authorize the doctors and staff of Marty Chiropractic to examine and treat _____ (name of patient).

Signed _____ Date _____

Patient Health History

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

First Name_____ **Last Name**_____

Date of Birth ____ ❑Male ❑Female **Marital Status** *(check one)*❑Single ❑Married

Contact Method *(check one)* ❑Primary Phone ❑Secondary Phone ❑Mobile Phone ❑Home Email ❑Work Email

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 ❑ Native Hawaiian or other Pacific Island ❑Other___❑ I choose not to specify

Multi-Racial *(check one)* ❑Yes ❑No

Ethnicity *(check one)* ❑Hispanic or Latino ❑Not Hispanic or Latino

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Other_____ ❑Choose not to specify

Verification Question *(choose only one question by marking the box next to 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: (SIX DIGITS OR MORE) _____

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 if known. If there are no current medications, check here: ❑

1) _____ **4)** _____

2) _____ **5)** _____

3) _____ **6)** _____

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

1) _____ **2)** _____

Family Medical History: Relative: M=Mother F=Father B=Brother S=Sister

Health Condition/Illness: ___Cancer(Type)_____ ___Heart Disease(Type)_____

___Stroke ____Hypertension ____Diabetes(Type)_____ ____Other _____

Has any doctor diagnosed you with Hypertension (high blood pressure)? ❑ Yes ❑ No If yes, describe:

_____

Has any doctor diagnosed you with Diabetes? ❑ 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: _____

Marty Chiropractic Patient History Form

Patient Name_____ Date_____

SYMPTOM 1_____ When did it start?_____

How did it begin? _____

Circle the average intensity of your Symptom 1 (none) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

What percentage of the day do you experience Symptom 1? 0 10 20 30 40 50 60 70 80 90 100

Is the symptom worse at certain times of day? Morning Afternoon Evening Night Unaffected by time of day

Circle all the qualities of Symptom 1: Sharp Dull ache Shooting Burning Throbbing Numb Radiating

What makes the symptom worse? _____

What makes the symptom better? _____

SYMPTOM 2_____ When did it start?_____

How did it begin? _____

Circle the average intensity of your Symptom 2 (none) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

What percentage of the day do you experience Symptom 2? 0 10 20 30 40 50 60 70 80 90 100

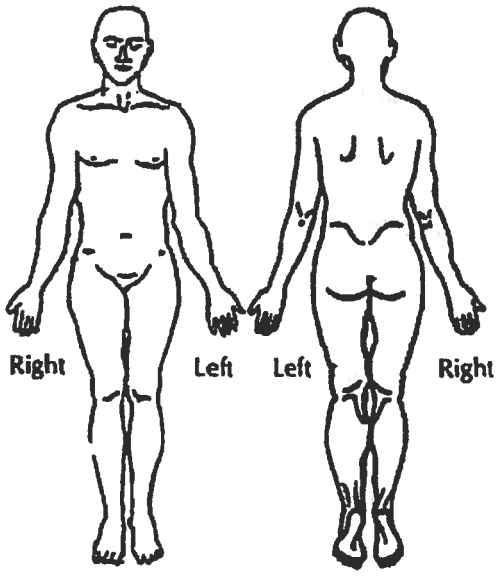
Is the symptom worse at certain times of day? Morning Afternoon Evening Night Unaffected by time of day

Circle all the qualities of Symptom 2: Sharp Dull ache Shooting Burning Throbbing Numb Radiating

What makes the symptom worse? _____

What makes the symptom better? _____

Indicate on the diagram where you have Symptom 1 and Symptom 2:



Have you had similar symptoms in the past? Yes No

Who have you seen for these symptoms? MD PT DC

Tests Performed: _____

Treatment Received: _____

What 3 ACTIVITIES are you having the most difficulty performing because of your chief complaint?

1._____

2._____

3. _____

Patient Health Questionnaire - page 2

American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
						○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Pregnancy
○	○	Arthritis	○	○	Hepatitis	○	○	
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder			
						Other Health Problems/Issues		
○	○	General Fatigue	○	○	Cancer	○	○	
○	○	Muscular Incoordination	○	○	Tumor	○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ **Date** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ **Date** _____