City Lakes Chiropractic

2903 E 42nd Street
Minneapolis, MN 55406
612-722-2147

Patient Registration and History

Please take a moment to complete the following intake form so we may obtain all necessary information in regard to your care.
If you have any questions please ask our office staff for assistance.

General Information

Date ____/____/____

Last Name _____ First Name _____ MI _____

Preferred Name (nickname) _____ Date of Birth ____/____/____ Age _____ ☐ Male ☐ Female

Street Address _____ City _____ State _____ Zip _____

Home Phone (____)_____ Cell Phone (____)_____ Email _____

Social Security # _____ Employer/School_____ Work Phone (____)_____

Occupation _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Spouse/Partner's Name _____ Phone (____)_____

Emergency Contact _____ Relation _____ Phone (____)_____
(other than above)

Referred by _____

Insurance Information (please present all insurance cards for photo copying)

Current Health Insurance Coverage ☐ Medicare ☐ Medicaid ☐ Health Insurance/Other ☐ None

Primary Insurance Carrier _____ Name of Insured _____

Relation _____ Insured DOB _____ Health Savings/Reimbursement account? ☐ Yes ☐ No

Secondary Insurance? ☐ Yes ☐ No if yes, Secondary Insurance Carrier _____

Name of Insured _____ Relation _____ DOB _____

Is current condition related to an accident? ☐ No ☐ Yes if yes please provide date of accident _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other _____

To who have you reported your accident? ☐ Auto Insurance ☐ Employer ☐ Other _____

Accident/Injury Insurance _____ Claim # _____

Attorney _____ Phone _____

Continued on next page

Reason for Visit *(Please describe the reason for your visit today)*

Chief Complaint (main reason for your visit) **PLEASE ONLY LIST ONE – OTHER SYMPTOMS CAN BE LISTED BELOW**

_____

OTHER please list any additional symptoms here: _____

_____

_____

Approximate date symptoms began _____ Have you had a similar condition in the past? ❑ Yes ❑ No

Have you received treatment for the above in the past? ❑ Yes ❑ No Type of treatment_____

Have you had x-rays or scans in the past 6 months in regard to the above? ❑ Yes ❑ No If yes please list date and type below:

_____

Below are lists of diseases and symptoms which may appear unrelated to the purpose of your appointment. However, please answer the questions carefully as such problems can have an effect on your overall course of chiropractic care:

Please check any of the following diseases you have past or present or check NONE if none of the following apply:

√ ❑ **None**

- ❑ Pneumonia
- ❑ Multiple Sclerosis
- ❑ Polio
- ❑ Tuberculosis
- ❑ Leukemia
- ❑ Anemia
- ❑ Measles
- ❑ Mumps
- ❑ Asthma
- ❑ Osteoporosis
- ❑ Diabetes
- ❑ Cancer
- ❑ Heart Disease
- ❑ Thyroid Problem
- ❑ Influenza
- ❑ Pleurisy
- ❑ Arthritis
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ Lumbago
- ❑ Eczema
- ❑ HIV/AIDS
- ❑ Eating Disorder
- ❑ Crohn's Disease
- ❑ Irritable Bowel Disease
- ❑ Other (please list) _____

_____

_____

Please place a check next each of the following that apply to your <u>current</u> condition:
If none apply please check NONE where appropriate

<u>MUSCULOSKELTAL</u>

√ ❑ **None**

- ❑ Neck pain
- ❑ Pain between shoulders
- ❑ Low back pain
- ❑ Shoulder pain
- ❑ Arm pain
- ❑ Leg pain
- ❑ Joint pain or stiffness
- ❑ Problems walking
- ❑ Swelling of hands or feet
- ❑ Muscle Cramps
- ❑ General Stiffness
- ❑ Jaw pain/clicking

<u>NEUROLOGIC/PSYCHIATRIC</u>

√ ❑ **None**

- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusion
- ❑ Depression/Anxiety
- ❑ Fainting
- ❑ Convulsions
- ❑ Cold/Tingling Extremities
- ❑ Stress

<u>GASTRO-INTESTINAL</u>

√ ❑ **None**

- ❑ Lack of Appetite
- ❑ Excessive Appetite
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Excessive Thirst
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Frequent Gas/Bloating
- ❑ Heartburn
- ❑ Black/Bloody Stool
- ❑ Colitis
- ❑ Liver Problems
- ❑ Gall Bladder Problems
- ❑ Abdominal Cramps
- ❑ Weight loss/gain

<u>GENITOURINARY</u>

√ ❑ **None**

- ❑ Bladder Problems
- ❑ Excessive Urination
- ❑ Painful Urination
- ❑ Discolored Urine

<u>CARDIOVASCULAR/RESPIRATORY</u>

√ ❑ **None**

- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Irregular Heart Beat
- ❑ Heart Disease
- ❑ Lung Problems/Congestion
- ❑ Varicose Veins
- ❑ Ankle Swelling
- ❑ Stroke

<u>ENT</u>

√ ❑ **None**

- ❑ Vision Problems
- ❑ Dental Problems
- ❑ Sore Throat
- ❑ Ear Aches
- ❑ Hearing Loss
- ❑ Sinusitis

<u>GENERAL</u>

√ ❑ **None**

- ❑ Fatigue
- ❑ Allergies
- ❑ Difficulty Sleeping
- ❑ Fever
- ❑ Frequent Headaches
- ❑ Migraine
- ❑ Weight Gain/Loss
- ❑ Rashes
- ❑ Hair Loss
- ❑ Excessive Dry Skin
- ❑ **Currently Pregnant**
- ❑ **Breast Feeding**

Past Medical History (please describe and list each date of occurrence)

☐ **None**

Major Surgeries _____

Major accidents or falls _____

Hospitalization (other than above)_____

_____

Family and Social History

Daily Habits: (circle answers)

Do you smoke? Yes No if yes, list amount per day _____ if you quit please list date _____

Do you consume alcohol? Yes No if yes, list frequency _____ per _____

Do you consume caffeine? Yes No if yes, list type and amount per day _____

Do you have a high level of stress? Yes No if yes, list main reason _____

Regular Exercise: None Light Moderate Intense Frequency _____ times per _____

Daily work includes: Sitting Standing Light lifting Moderate to heavy lifting Computer work
(check all that apply)

Family Health History:
Please list any significant health issues in your immediate family (mother, father, grandparents, siblings)

Family Member	Health Issue(s)

Medications
Please list below all medications you are currently taking. Please include over the counter and nutritional supplements:

1. _____ **for** _____ **5.** _____ **for** _____
2. _____ **for** _____ **6.** _____ **for** _____
3. _____ **for** _____ **7.** _____ **for** _____
4. _____ **for** _____ **8.** _____ **for** _____
5. _____ **for** _____ **9.** _____ **for** _____

Authorization and Release

Patient Name: _____

I authorize the release of any information concerning my health and health care services, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care, to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me under any insurance or pre-paid health plan.

I understand that the benefits quoted by my insurance company are not a guarantee of payment and all charges are considered at the time claims are processed. I understand that my insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I agree to notify your office of any and all insurance changes that would affect the filing of claims or payment for the treatment I receive.

I understand that payment in full is due at the time of service unless other arrangements have been made.

Signature of patient or guardian _____ **Date** _____

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatment) and any other associated procedures that may include but not limited to physical examination, diagnostic testing and x-ray and physical therapy procedures.

I understand with chiropractic treatment, as well as any health care procedures, there are certain risks and complications associated with this type of treatment. Such complications include but are not limited to: post treatment soreness or discomfort, soft tissue injury, dislocation, and fractures. Although rare, some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications. I wish to rely upon the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based on the facts then known, are in my best interest.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment. If you have any questions concerning the above, please ask your doctor of chiropractic.

Having carefully read the above, I give my informed consent to have chiropractic treatment administered.

Signature of patient or guardian _____ **Date** _____

Consent to Treat a Minor (if applicable)

Having carefully read the above, as the parent or legal guardian of _____ **I give my informed consent to allow chiropractic treatment to be administered to my child.**

Signature of patient or guardian _____ **Date** _____

HIPAA Privacy Practice Acknowledgement

I have received or was offered and declined a notice of privacy practices.

Signature of patient or guardian _____ **Date** _____