Hjort Chiropractic Patient History and Registration

Demographics:

First Name: ______________________ MI: ___ Last Name: _____________________ Date: _____________

Address_____________________________ Apt # _____ City______________ State_______ Zip__________

Sex: F____ M____ Age: _____ Birth date: ___________ Height: Feet ____ Inches ____ Weight: _______

Phone Numbers: Home: ____________________ Work: __________________ Cell: _______________________

Occupation: ____ Employer: ______________________________

Spouse's Name: ____ Birth date: ______________________

In Case of Emergency, Contact: Name: _______________________ Relationship: ___________________

Contact Number: Home: ____________________ Work: ________________ Ext: _____ Cell_______________

Referred By: [ ] Yellow Pages [ ] Location [ ] Internet Search [ ] Facebook [ ] You Tube

[ ] Personal Referral : ________________ [ ] Professional Referral: ________________

[ ] Other: _________________________ [ ] Insurance Provider Directory [ ] Dr. Undersander

If you would like to receive our informational newsletter, please provide your email address:

____

Preferred Language: _________________ Race: ___ American Indian or Alaska Native ___ Asian

Ethnicity: ___ Hispanic or Latino ___ White ___ Native Hawaiian or Other Pacific Islander

___ Not Hispanic or Latino ___ Black or African American ___ Other: _____________

Are you pregnant: No __ Yes __ Due Date: ________________

Current Complaint:

Reason for visit: ____

Have you had this problem in the past? [ ] N [ ] Y Have you had any treatment for this condition? [ ] N [ ] Y

If **YES** what kind of treatment, when and did it help? ____

When did symptoms begin? _________________ Are the symptoms getting: [ ] Better [ ] Worse [ ] Same

Rate your condition on a 0 to 10 scale: (0 feeling perfect to 10 being unbearable) ________

Rate how your daily living activities are affected on a 0 to 10 scale: (0 not at all to 10 being bedridden) _______

What are the intensity of your symptoms? [ ] Mild [ ] Moderate [ ] Severe [ ] Unbearable

What are the nature of your symptoms? [ ] Burning [ ] Dull Ache [ ] Numb [ ] Radiating [ ] Sharp

[ ] Shooting [ ] Stabbing [ ] Tightness [ ] Tingling [ ] Throbbing

What makes your condition better? [ ] Acupuncture [ ] Chiropractic [ ] Heat [ ] Ice [ ] Massage [ ] Nothing

[ ] Pain Medications [ ] Physical Therapy [ ] Sleep/Rest [ ] Stretching [ ] Other ______________________

What makes your condition worse? ____

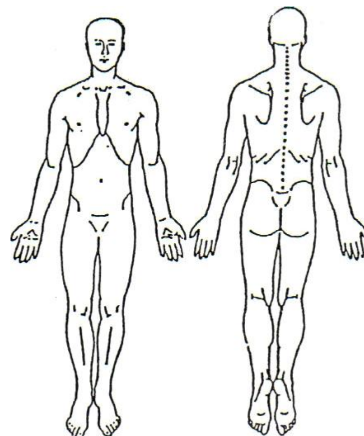
What are your expectations for care here? [ ] Become Pain Free [ ] Explanation of my Condition [ ] Learn How to Care for this Condition on my Own [ ] Reduce Symptoms [ ] Resume Normal Activity [ ] Other __________

What are your frequency of symptoms? [ ] Constant (76-100% of the day) [ ] Frequent (51-75% of the day

[ ] Occasional (26-50% of the day [ ] Intermittent (1-25% of the day)

Do you have a relevant family history of this condition? N ___ Y ___ If **YES** explain: ____________________

Mark an "**X**" on the picture where you have pain
And "**//**" where you have tingling and numbness:



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Reviewed By: _________ **Date:** _________

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Health History:
Please mark any of the following **surgeries** that you have had:
[ ] Appendix [ ] Ankle [ ] Back [ ] Brain [ ] Breast Augmentation
[ ] Breast Reduction [ ] Carpal Tunnel [ ] Chest [ ] Disc [ ] Eyes, Ears, Nose, Throat
[ ] Elbow [ ] Foot [ ] Gallbladder [ ] Gastrointestinal [ ] Gynecological
[ ] Heart [ ] Hernia [ ] Hip [ ] Hip Replacement [ ] Knee
[ ] Knee Replacement [ ] Kidney [ ] Neck [ ] Obstetrical [ ] Shoulder
[ ] Skin [ ] Wrist/Hand [ ] Other ____

Review of Systems:
Please mark any of the following **problems** that you have had:
[ ] Anemia [ ] Ankle Pain [ ] Arm Pain [ ] Arthritis [ ] Anorexia
[ ] Asthma [ ] Autism [ ] Back Pain [ ] Bleeding Disorders [ ] Broken Bones
[ ] Bulimia [ ] Cancer [ ] Chemical Dependency [ ] Chest Pain [ ] Concussions
[ ] Diabetes [ ] Dizziness [ ] Ear Problems [ ] Elbow Pain [ ] Emphysema
[ ] Epilepsy [ ] Eye/Vision Problems [ ] Fainting [ ] Fatigue [ ] Foot Pain
[ ] Fibromyalgia [ ] Genetic Spinal Disorder [ ] Glaucoma [ ] Goiter [ ] Gout
[ ] Hand Pain [ ] Headache [ ] Hearing Problems [ ] Heart Burn [ ] Heart Disease
[ ] Hepatitis [ ] High Blood Pressure [ ] High Cholesterol [ ] Hip Pain [ ] Jaw/TMJ Pain
[ ] Joint Stiffness [ ] Kidney Disease [ ] Knee Pain [ ] Leg Pain [ ] Liver Disease
[ ] Lung Disease [ ] Lupus [ ] Menstrual Problems [ ] Migraines [ ] Miscarriage
[ ] Mouth Problems [ ] Multiple Sclerosis [ ] Neck Pain [ ] Nose Problems [ ] Osteoporosis
[ ] Pacemaker [ ] Palpitations [ ] Parkinson's Disease [ ] Pinched Nerve [ ] Pneumonia
[ ] Polio [ ] Premature Birth [ ] Prostate Disease [ ] Prosthetic Limb [ ] Psychiatric Care
[ ] Rheumatoid Arthritis [ ] Seizures [ ] Shoulder Pain [ ] Significant Weight Change
[ ] Sleep Apnea [ ] Spinal Cord Injury [ ] Stroke [ ] Stomach Problems [ ] Suicide Attempt
[ ] Thyroid Disease [ ] Tuberculosis [ ] Tumor [ ] Ulcers [ ] Wrist Pain
[ ] Other ____

Have you been diagnosed with any of the following: spinal cancer or infection [ ] N [ ] Y, recent spinal fracture or dislocation [ ] N [ ] Y, major artery aneurysm [ ] N [ ] Y, bleeding disorder or anti-coagulant therapy [ ] N [ ] Y, vertebra-basilar insufficiency [ ] N [ ] Y, unstable odontoid [ ] N [ ] Y, acute arthropathy [ ] N [ ] Y. If **YES,** explain: ____

Habits: [ ] Water - 8oz Glasses/day ____________ **Exercise**: [ ] None **Work Activity**: [ ] Sitting
[ ] Alcohol - Drinks/week ______________ [ ] Moderate [ ] Standing
[ ] Caffeinated Drinks - Cups/day _______ [ ] Daily [ ] Light Labor
[ ] High Stress Level - Reason__________ [ ] Heavy [ ] Heavy Labor

Smoking Status: __ Current Every day Smoker __ Current Some Day Smoker__ Former Smoker__Never Smoker
Medications: ____
Medication Allergies: ____
Vitamins/Herbs/Minerals: ____
Non-Medication Allergies: [ ] None [ ] Animals/Pets [ ] Bee Stings [ ] Chocolate [ ] Dairy [ ] Dust [ ] Eggs [ ] Dyes [ ] Latex [ ] Molds [ ] Pollen [ ] Rubber [ ] Seasonal [ ] Shellfish [ ] Soaps [ ] Gluten

Have you had any of the following? If so, when and describe:
Falls ____
Car Accidents ____
Work Injuries ____

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Reviewed By: ________ Date: ________
First Name: ____________________ Last Name: ______________________ DOB: __________________ Date: ____________________

Hjort Chiropractic

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Hjort Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Are you the policy holder? N _____ Y _____

If no, who is the Policy Holder: ___________________________ Date of Birth of Policy Holder: ___________

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Hjort Chiropractic to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at **320-251-3450**. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending chiropractor and it is the responsibility of the staff to carry out the instructions of such chiropractor(s).

Any procedure intended to help, may also do harm. While chiropractic examination and therapeutic procedures (e.g. spinal adjustments, ultrasound, heat, and cold application, electrotherapy, and manual therapy) are considered remarkably safe and effective, please understand that occasionally there may be adverse reactions.

Although the chances of experiencing any of these complications are extremely small, it is the practice of this chiropractic office to fully inform and educate all of our patients. These complications include, but are not limited to: pain, swelling, bruising, discoloration, inflammation, disc injury, sensory changes, bleeding, bone fracture, nausea, burns, soft tissue injury, stroke, dizziness, weakness, worsening of condition-spinal cord damage.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and /or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

I understand that there is no guarantee or warranty for a specific cure or result.
I understand that I can request further explanation regarding any and all possible risks attendant to my care.

Signature: ____ Date: ___________________________

Guardian: ____ Date: __________________________

Office Use Only
First Name: ______________________ **Last Name:** ____________________ **DOB:** ______________ **Date:** __________