Nesseth Chiropractic Clinic
235 Broadway Ave S
Cokato, MN 55321
320-286-6336

Patient Information Sheet **Today's Date:**_____

PATIENT:

Last Name:_____First:_____Middle:_____
Gender: M F Date of Birth:___ / ____ / _____ Age:_____SS#:_____
Address:_____City:_____ MN:____Zip code:_____
Home Phone# (_____) _____-_____ Cell Phone# (_____) _____-_____
Email address:_____
May we contact you by email? Y N

SPOUSE or GUARDIAN:

Last Name:_____First:_____Middle:_____
Day Time Phone# (____) _____-_____D.O.B.:_____/ _____/_____

EMERGENCY CONTACT:

Last Name:_____First:_____Middle:_____
Day Time Phone# (____) _____-_____Relationship to Patient:_____

EMPLOYER:

Name:_____Occupation:_____
Address:_____Work# (_____) _____-_____
City:_____State:_____Zip:_____May we contact you at work? Y N

INSURANCE: Please present card to obtain a photo copy.

Insurance Carrier:_____Policy #_____
Insured's Last Name:_____First Name:_____MI____
D.O.B._____/_____/_____Who carries this policy? Self Spouse Parent

*****IF WORK COMPANSATION OR AN AUTO CLAIM PLEASE NOTIFY THE RECEPTIONIST*****

RESPONSIBLE PARTY:

Name:_____Relationship to patient:_____
Day time Phone# (____) _____-_____

TODAY'S VISIT:

What is your main concern:_____
When did it start/What were you doing?_____
What have you done? (Ice, heat, medications)_____
Have you seen a Chiropractor before? Y N When?_____Whom?_____

SIGNATURE: (Patient, Parent, Legal Guardian or Responsible Party)

X_____

Nesseth Chiropractic Clinic

Patient Health Information Consent Form (PHI)

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how our records will be used. If you would like to have more detailed account of our policies and procedures concerning the privacy of your PHI, we encourage you to read the **HIPPA NOTICE** that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this Chiropractic office to use the **PHI** for the purpose of treatment, payment, healthcare operations and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their **PHI**. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This written request to revoke consent would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and privacy official has been designated to enforce those procedures in our office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the Chiropractic physician has the right to refuse to give care.

I have read and understand how my **PHI** will be used and I agree to these policies and procedures.

Signature of Patient _____Date:___/___/____
(Guardian if under 18yrs of age)

Terms of Acceptance

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's corrections of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnosis or treat any disease, nor do we offer advice regarding treat prescribed by others. We only offer to diagnosis either vertebral subluxation or neuromuscular skeletal conditions. Our only method is specific adjusting to correct vertebral subluxations.

I have read and fully understand the above statements. All questions regarding the doctor's objective pertaining to my care in this office have answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

Signature of Patient _____Date: ___/___/____
(Guardian if under 18yrs of age)

Nesseth Chiropractic Clinic GENERAL HISTORY FORM Date:_____

Please check all symptoms you are currently experiencing, or have had significant difficulty with in the past.

O Headaches	O Foot pain R/L	O Menstrual irregularity
O Neck pain/stiffness	O Depression	O Infertility
O Knee pain R/L	O Lower back pain/stiffness	O Anxiety
O Shoulder pain R/L	O Sciatica	O Cold hands/feet
O Pins/needles in arm	O Pins/needles in legs	O Constipation
O Numbness in fingers	O Hot flashes	O Asthma
O Sinus problems	O Heartburn/ulcers	O Diarrhea
O Allergies	O Sleeping problems	O Skin conditions
O Upper back pain	O Frequent colds/flu's	O Fatigue/low energy
O Elbow pain R/L	O Diabetes Type 1 or 2 duration_____	

O Cancer, type_____treatment date_____surgery_____
O Heart Disease, heart attack_____ surgery_____date_____
O Autoimmune disorder, type_____treatment_____duration_____
O Osteoporosis, date diagnosed_____

If you would like to expand on any checked symptoms or inform us of something we may have left out, please feel free to write down your comments:

_____
_____

Please list any medications you are currently taking and why:

_____
_____

Have you had any surgeries and/or hospitalizations? YES NO
If yes, reason and date:

_____
_____

If you participate in sports what kind and how intense is the training?

_____

Do you think you may need a form restricting you from activities? YES NO

MISC:
Do you smoke? YES NO Are you pregnant? YES NO Due date:_____
Do you want information on acupuncture/weight loss/nutrition? YES NO
If yes, for what reason_____

Signature:_____
(patient, parent, legal guardian or responsible party)