NEW PATIENT INTAKE

Globa Chiropractic, P.A. 9580 Noble Parkway North, Brooklyn Park, MN 55443 Phone (763)370-5993 Fax (763)561-2651

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M or F Marital Status: S M D

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____ Email: _____

Employer: _____ Occupation: _____

Name of Spouse: _____ Spouse's Date of Birth: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Referred to Our Office By: _____

Are Your Complaints Related to a Work Injury? Y or N

Are Your Complaints Related to an Auto Accident? Y or N

Method of Payment: Cash Insurance

If insurance we will take a Copy of Your Insurance Card(s)

Patient Informed Consent:

I, _____<print name>_____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature: _____ **Date:** _____

CHIROPRACTIC PATIENT HISTORY

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Location:

What Is Your Primary Complaint? _____

What Caused The Onset? _____

When Did It Start? _____/_____/_____

Does the Complaint Radiate or Travel? If so, Where? _____

Timing and Duration:

✓ Since the onset of your complaint how has it been changing? ☐ Getting Better ☐ Not Changing ☐ Getting Worse

✓ How often do you experience this complaint? ☐ Constantly (100%) ☐ Frequently (75%) ☐ Occasionally (50%) ☐ Intermittently (25%)

✓ Does your complaint worsen? If so, When? ☐ Morning ☐ Midday ☐ Night ☐ Sleep ☐ Work ☐ Other: _____

✓ How much has the complaint interfered with your normal work? (including both work outside the home, and housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

✓ How much would you say this complaint has affected your social activities?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

Severity:

Use the key below to rate the severity of your pain.

☐ Mild ☐ Moderate ☐ Severe

Quality:

✓ How would you describe the sensation of your complaint?

☐ Sharp pain ☐ Shooting ☐ Numbness ☐ Tingling

☐ Dull Ache ☐ Burning ☐ Throbbing ☐ Other: _____

Modifying Factors:

✓ What makes your complaint feel worse?

☐ Coughing / Sneezing ☐ Standing ☐ Lifting ☐ Exercising ☐ Bending ☐ Twisting

☐ Pushing / Pulling ☐ Sitting ☐ Walking ☐ Driving ☐ Climbing ☐ Other: _____

Alleviating Factors:

✓ What makes your complaint feel better?

☐ Rest / Sleep ☐ Stretching ☐ Lifting ☐ Exercising ☐ Bending ☐ Twisting

☐ Pain Medication ☐ Ice ☐ Heat ☐ Shower ☐ Walking ☐ Other: _____

Previous Treatment:

Who have you seen for this condition? ☐ Medical Doctor ☐ Physical Therapist ☐ Chiropractor ☐ Other: _____

Have you had Chiropractic care in the past? ☐ Yes ☐ No If so, When? ___/_____/____

Risk Factors:

Do you have a pace maker? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No ☐ Maybe

Do you have any metal implants or devices? ☐ Yes ☐ No

History was obtained from: ☐ Patient ☐ Parent ☐ Guardian ☐ Child ☐ Other: _____

Patient / Guardian Signature: _____ Date: _____

Dr: _____

PAST AND GENERAL HISTORY

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Past History: Please Mark Below With an "X"

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition	Past	Present	Allergies
X		Example	X	X	Example		X	Example	X	X	Example
		Angina / Chest Pain			Heart Problems			Seizures			Animal Dander
		Arthritis			HIV			Sleeping Problems			Latex
		Asthma			Irritability			Soreness			Food Allergies
		Back Pain			Joint Stiffness			Speaking Problems			Penicillin
		Balance Problems			Joint Swelling			Spinal Curvature			Pollen
		Broken Bones			Joint Tenderness			Stiffness			Smoke
		Cancer			Loss of Sleep			Stroke / TIA			Grasses
		Chills			Lumps			Tingling			Sulfa Drugs
		Concentration Loss			Masses			Thyroid Problems			Dairy Products
		Diabetes			Memory Loss			Tremors			Perfumes
		Dizziness			Muscle Cramps			Vertigo			Hay
		Fatigue			Muscle Pain			Weakness			Other Please List:
		Fainting			Nervousness			Other Please List:			
		Fever			Night Sweats						
		Gout			Numbness						
		Headaches			Paralysis						

Medication and Surgical History:

Surgery	Yes	No	Year	Surgery	Yes	No	Year	Have You Ever Taken:	Yes	No	Year
Tonsils				**Women**				Insulin			
Colon				Breast				Cortisone			
Hernia				Uterus				Thyroid Medication			
Appendix				Ovaries				Male / Female Hormones			
Gall Bladder								Blood Pressure Medication			
Stomach				**Men**				Cholesterol Medication			
Heart				Prostate				Anti-Depressants			
Kidney								Tranquilizers / Sedatives			
								Birth Control			

What Other Supplements, Vitamins or Medications Are You Taking? _____

_____

_____

Injury History:

What, If Any, Major Injuries Have You Had? When? _____

_____

_____

Have You Been Hospitalized? If so, When and Why? _____

_____

_____

Patient / Guardian Signature: _____ Date: _____

Dr: _____

SOCIAL AND FAMILY HISTORY

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Social History:

✓ **What Is The Highest Level of Schooling You Have Completed?**
☐ Still in School ☐ Some High School ☐ High School ☐ Some College ☐ College ☐ Graduate School

✓ **What Is Your Current Work Status?**
☐ Employed Full Time ☐ Employed Part Time ☐ Retired ☐ Unemployed ☐ Disabled ☐ Student

✓ **How Often Do You Exercise?**
☐ Never ☐ 1-3 times per month ☐1-2 times per week ☐ 3-4 times per week ☐ daily

✓ **How Would You Rate The Intensity Of Your Exercise?**
☐ Never Exercise ☐ Low Level ☐ Moderate Level ☐ High Level ☐ Competition level

✓ **How Many Hours Do You Sleep Per Night?**
☐ <4 hours ☐ 5-6 hours ☐ 7-8 hours ☐ 8-10 hours ☐ >10 hours

✓ **How Often Do You Eat A Balanced Diet?**
☐ Never ☐ Rarely ☐ Sometimes ☐ Regularly ☐ Always

✓ **How Often Do You Drink Caffeinated Beverages?**
☐ Never ☐ 1-3 Times Per Month ☐ 1-2 Times Per Week ☐ 3-4 Times Per Week ☐ Daily ☐ >2 Per Day

✓ **How Often Do You Smoke Cigarettes?**
☐ Never ☐ Past ☐ 1-3 packs per month ☐ 1-2 packs per week ☐ 3-4 packs per week ☐ >1 pack per day

✓ **How Often Do You Drink Alcohol?**
☐ Never ☐ Past ☐ 1-3 drinks per month ☐ 1-2 drinks per week ☐ 3-4 drinks per week ☐ daily

✓ **Have You Used Illicit / Street Drugs In The Past 6 Months?**
☐ No ☐ Yes

Daily Activities:

So that we may have an idea as to your daily routine please list a few of your daily activities and your favorite hobbies:

_____

_____

✓ **Does Your Current Condition Affect Your Performance In These Activities Or Hobbies?**
☐ Yes ☐ No If So How:_____

Family History Information:

✓ **Please Indicate If Anyone In Your Family Currently Has, Or Has In The Past, Suffered From Any Of The Conditions Listed Below:**

✓ **Arthritis:**
☐Yes ☐ No Whom:_____

✓ **Back Pain:**
☐Yes ☐ No Whom:_____

✓ **Cancer:**
☐Yes ☐ No Whom:_____

✓ **Diabetes:**
☐Yes ☐ No Whom:_____

✓ **Heart Disease:**
☐Yes ☐ No Whom:_____

✓ **High Blood Pressure:**
☐ Yes ☐ No Whom:_____

✓ **High Cholesterol:**
☐ Yes ☐ No Whom:_____

✓ **Osteoporosis:**
☐ Yes ☐ No Whom:_____

✓ **Stroke:**
☐ Yes ☐ No Whom:_____

✓ **Thyroid Conditions:**
☐ Yes ☐ No Whom:_____

Patient / Guardian Signature: _____ Date: _____

Dr: _____

ASSIGNMENT OF BENEFITS/ PATIENTS AUTHORIZATION FORM

Globa Chiropractic, P.A. 9580 Noble Parkway North, Brooklyn Park, MN 55443 Phone (763)370-5993 Fax (763)561-2651

- As a courtesy to you, we will complete and submit all necessary claim forms to your insurance company; however, it is important to understand that you are ultimately responsible for payment of any and all charges incurred by you during your treatment.
- I hereby authorize and direct you, my insurance company, and/or my attorney to pay directly to Globa Chiropractic, P.A., for all charges incurred in the clinic during my course of treatment. I also authorize the release of any information required to process all valid insurance claims filed on my behalf.

Patient / Guardian Signature: _____ **Date:** _____

Patient Consent Form

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-rays, and physical therapy techniques, on me.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts he knows, are in my best interest.

I will exercise my right to discuss with the doctor the nature, purpose and risks of chiropractic adjustments and other recommended procedures in order to have all my questions answered to my satisfaction prior to treatment. I further understand that the results are not guaranteed.

By signing below, I state that I have decided it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) of which I seek treatment.

Patient / Guardian Signature: _____ **Date:** _____

HIPPA NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have the right to receive and review and agree to the notice of privacy practices of Globa Chiropractic, P.A. which describes the Practice's policies and procedures regarding the use and disclosure of any of my protected health information created, received, or maintained by Globa Chiropractic, P.A.

Patient / Guardian Signature: _____ **Date:** _____

AUTHORIZATION FOR TREATMENT OF A MINOR

I hereby authorize Globa Chiropractic, P.A. to provide treatment for my child.

Child's Name _____

Patient / Guardian Signature: _____ **Date:** _____