the CONNECTION a chiropractic place

111 Main St N -
Stewartville, MN
55976
P: 507.533.8011

CONFIDENTIAL PATIENT HEALTH RECORD

ABOUT YOU

Name: _____ DOB: ___/___/_____ Date: ___/___/_____
First M.I. Last

Address: _____ SSN: _____-_____-_____ # of Children: _____
Street/PO Box

_____ Email Address: _____
City, State Zip

Phone: (_____)_____-_____ (_____)_____-_____ Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Other
Home Cell

Employer: _____ Spouse's Name: _____

Work Phone: (_____)_____-_____ EXT_____ May we talk to you spouse about your account? ☐ Y ☐ N

May we call you at work? ☐ Y ☐ N Who referred you to the clinic? _____

FOR MINORS/IF UNDER 18 YEARS OLD ONLY: Have you seen or heard of our clinic because of/from:

Parent/Guardian Name: _____ ☐ Sign ☐ Yellow Pages ☐ Community Event

Parent/Guardian Address (if different from above): ☐ Website ☐ Mailing ☐ Newspaper

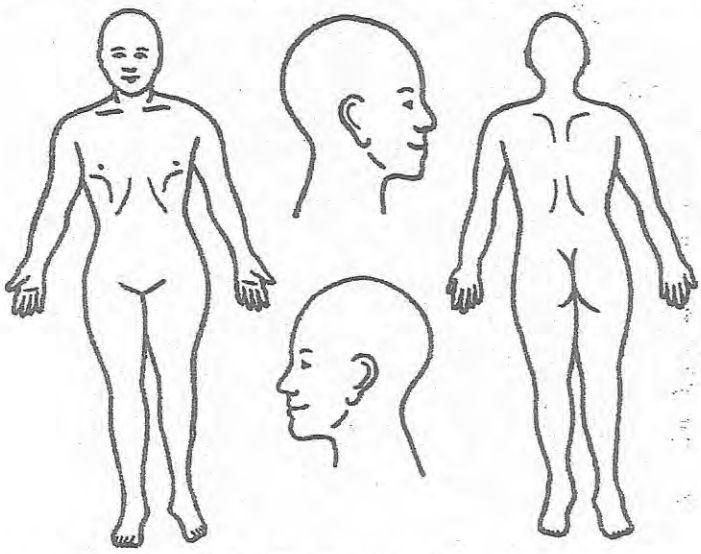
_____ ☐ Other: _____
Street/PO Box City, State Zip

Phone: (_____)_____-_____ (_____)_____-_____
Home Cell

Parent/Guardian permission to examine, x-ray and treat minor: X_____

HOPI: REASON FOR THIS VISIT

Please use the following symbols and mark on the diagram below the location(s) of your discomfort:



XXX Burning
((((Aching
000 Pins & Needles
:::: Numbness
---- Sharp

For Office Use Only
☐ Constant
☐ Intermittent
☐ Getting Worse
☐ Getting Better
☐ Not Changing

Better		Worse
☐	AM	☐
☐	Midday	☐
☐	PM	☐
☐	Night	☐

Please indicate the intensity of your symptoms:

0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Describe the reason(s) for this visit: _____

_____

Is the purpose of this appointment related to: ☐ Wellness Care ☐ Work Related Injury ☐ Auto Accident/Personal Injury ☐ Sports Injury ☐ Other: _____

When did the symptoms begin? ___/___/_____ How did the symptoms begin? _____

_____

What daily activities are painful, difficult or limited because of the symptom(s)? ☐ Sleep ☐ Work ☐ Daily Routine ☐ Other: _____

What makes the symptom(s) ***better***?
☐ Ice ☐ Heat ☐ Postural Changes
☐ Other: _____

What makes the symptom(s) ***worse***?
☐ Certain Movements ☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lifting ☐ Other: _____

Does it cause pain to cough/sneeze? ☐ Yes ☐ No If yes, where is the pain located? _____

Have you experienced these symptoms before? ☐ Yes ☐ No

Who have you seen before for symptoms? ☐ No one ☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other: _____

the CONNECTION a chiropractic place

Patient Name: _____

Date: ___/___/_____

QUESTIONS FOR HEADACHES & NECK

Y	N	
☐	☐	Do you experience nausea, vomiting or visual disturbances?
☐	☐	Do you have painful or cracking jaw?
☐	☐	Do you have abnormal blood pressure?
☐	☐	Do you have a family history of headaches?
☐	☐	Do you have a neck injury that affects hearing, vision, balance or ringing in your ears?
☐	☐	Do you hear grating sounds?
☐	☐	Do you have a feeling of ripping or tearing?
☐	☐	Do you sleep with a pillow?

Frequency of headaches: ☐ everyday OR ____ times per ☐ week ☐ month

What position do you sleep in? ☐ Back ☐ Side ☐ Stomach

Date of last exam by an eye doctor: _____/_____

QUESTIONS FOR LOW BACK

Y	N	
☐	☐	Do you have a feeling of ripping or tearing? If so, where is it located? _____
☐	☐	Does pain radiate into the abdomen?
☐	☐	Do you have impairment of bowel/urinary function? If so, explain: _____
☐	☐	Does it cause pain to cough, grunt or sneeze? If so, where is it located? _____

HEALTH RELATED

Y	N	
☐	☐	Any recent weight changes?
☐	☐	Any recent changes in diet?
☐	☐	Do you have night sweats?
☐	☐	Do you bruise easily?
☐	☐	Do you have fever of long duration?
☐	☐	Do you smoke or chew tobacco? # of packs per day ____; # of years _____
☐	☐	Do you drink coffee, soda or tea? # of caffeinated drinks per day ____
☐	☐	Do you exercise regularly? Type: _____ Days per week: _____

Do you wear: ☐ Heel Lifts ☐ Orthotics ☐ Braces/Supports

YOUR CONCERNS: SYSTEMS REVIEW

Past	Present		Past	Present	
☐	☐	Headaches/Migraines	☐	☐	Diarrhea
☐	☐	Neck Pain	☐	☐	Constipation
☐	☐	Dizziness	☐	☐	Colitis/Crohn's Disease
☐	☐	Vision Problems	☐	☐	Irritable Bowel
☐	☐	Difficulty Concentrating	☐	☐	Hepatitis
☐	☐	Allergies	☐	☐	Low Back Pain
☐	☐	Hearing Problems	☐	☐	Leg Pain/Numbness
☐	☐	Jaw Pain	☐	☐	Bladder Problems
☐	☐	General Fatigue	☐	☐	Menstrual Issues
☐	☐	Sore Throat	☐	☐	Prostate Issues
☐	☐	Shoulder Pain	☐	☐	Reproductive Problems
☐	☐	Elbow/Upper Arm Pain	☐	☐	Diabetes
☐	☐	Wrist/Hand Pain or Numbness	☐	☐	Excessive Thirst
☐	☐	Asthma/Difficulty Breathing	☐	☐	Frequent Urination
☐	☐	Bronchitis/Pneumonia	☐	☐	Osteoarthritis
☐	☐	High Blood Pressure	☐	☐	Rheumatoid Arthritis
☐	☐	Heart Conditions	☐	☐	Systemic Lupus
☐	☐	Stroke	☐	☐	Epilepsy
☐	☐	Middle Back Pain	☐	☐	Cancer/Tumors
☐	☐	Gallbladder Issues	☐	☐	HIV/AIDS
☐	☐	Ulcers	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Indigestion/Upset Stomach	☐	☐	Other: _____
☐	☐	Vomiting	☐	☐	Other: _____

FOR WOMEN ONLY

Y	N	
☐	☐	Are you pregnant? If so, due date: ___/___/_____
☐	☐	Are you nursing?
☐	☐	Are you taking birth control?
☐	☐	Do you experience painful periods?
☐	☐	Do you have regular menstrual cycles?
☐	☐	Do you have breast implants?

Date of last gynecological and breast examination: ___/___/_____

Date of last colonoscopy: ☐ N/A ___/___/_____

Complications, abnormalities, new diagnoses: _____

Primary Care Physician: _____ @ _____

FOR MEN ONLY

Date of last prostate exam: ___/___/_____ Date of last colonoscopy: ☐ N/A ___/___/_____

Complications, abnormalities, new diagnoses: _____

Current prostate issues: _____

Primary Care Physician: _____ @ _____

PAST MEDICAL HISTORY

Thinking back to childhood and moving forward to the present, please list any injuries, accidents, falls, surgeries and/or hospitalizations:

Type	Area	Treatment	Complications

MEDICATIONS

Please check all that apply:

☐ Cholesterol Meds
☐ Blood Pressure Meds
☐ Blood Thinners
☐ Other: _____
☐ Depression Meds
☐ Anxiety Meds
☐ Insulin
☐ Other: _____
☐ Muscle Relaxers
☐ Stimulants
☐ Pain Killers
☐ Other: _____
☐ Vitamins/Supplements: _____

FAMILY HISTORY

Please indicate if any immediate family member has any of the following:

☐ Rheumatoid Arthritis
☐ Diabetes
☐ Other: _____
☐ Heart Problems
☐ Lupus
☐ Other: _____
☐ Cancer
☐ Alzheimer's
☐ Other: _____

CHIROPRACTIC EXPERIENCE

☐ Y ☐ N Have you been adjusted by a chiropractor before?

Approximate date of last treatment: ____/____/_____

Previous chiropractic treatment (check all that apply):

☐ Manual Adjustments ☐ Electrical Muscle Stimulation ☐ Decompression/Traction
☐ Activator Adjustments ☐ Ultrasound ☐ Other: _____
☐ Drop Table Adjustments ☐ Cold Laser ☐ Other: _____

GOALS FOR YOUR CARE

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for the corrections of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Wellness Care**—Bringing whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.
☐ **Corrective Care**—Correcting and relieving the cause of the problem as well as the symptom.
☐ **Acute Care**—Symptomatic relief of pain or discomfort.

PATIENT HEALTH INFORMATION INFORMED CONSENT

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

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or 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 these restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any 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 a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this 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 Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature: X _____ **Date:** ____/____/_____
Guardian Signature: X _____
D.C. Signature: _____ **Date:** ____/____/_____

FOR OFFICE USE ONLY:
Additional Notes: _____

Patient Goals: 1) _____ 3) _____
2) _____ 4) _____