

CONFIDENTIAL PATIENT HISTORY

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE () _____ WORK PHONE () _____

OCCUPATION _____

EMPLOYER _____

EMPLOYER'S ADDRESS _____

EMPLOYER'S PHONE (____) _____ NAME OF CONTACT _____

SOCIAL SECURITY NUMBER ____ - ____ - ____ BIRTHDATE _____

MARITAL STATUS S M D W

SPOUSE'S NAME _____

SPOUSE'S SOCIAL SECURITY # ____ - ____ - ____ NUMBER OF CHILDREN _____

SPOUSE'S EMPLOYER AND PHONE _____

REFERRED TO THIS CLINIC BY: _____

INSURANCE

Primary Insurance

Medica

Preferred One

Medical Assistance

Blue Cross Blue Shield

Worker's Compensation

Personal Injury

Medicare

Other _____

Have you had x-rays taken on your neck, middle back or lower back in the past 3 years?

____ YES ____ NO If yes, at which clinic? _____

Secondary Insurance

Please list, if any _____

Emergency Contact Name _____

Emergency Physician _____

PATIENT SIGNATURE _____ Date _____

Thank you for your cooperation in helping us to keep our records current.

Annandale Family and Sports Chiropractic 5/07

**ANNANDALE FAMILY & SPORTS CHIROPRACTIC
INFORMED CONSENT FORM**

As with any healthcare procedure, I understand that there are certain complications, which may arise during chiropractic manipulation, and that those complications include: fractures, disc injuries, dislocations, muscle strain, Horner’s syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone. I also understand that stroke and other complications are also generally described as “rare.”

Doctors of Chiropractic, Medical Doctors and Physical Therapists using manual therapy treatments for patients with headache and cervical spine (neck) complaints, are required to specifically explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The chances of this happening are estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments.

Appropriate tests and history will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your Doctor of Chiropractic.

In signing this document, I in no way compromise my protection against negligence.

I have read and understand the above statement and hereby consent to treatment.

Patient Signature

Date

Witness Signature

Date

Patient Health Questionnaire - PHQ

ChiroCare Form PHQ-202

ChiroCare Use Only rev 5/27/2003

Patient Name _____ Date _____

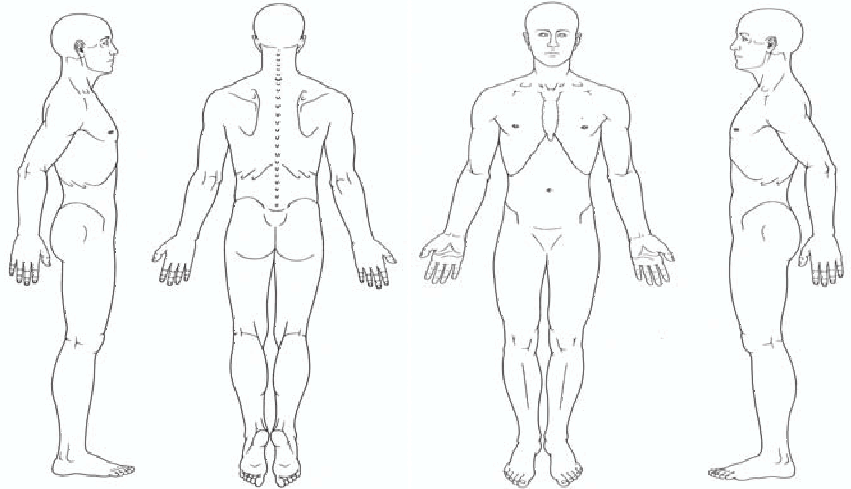
1. Describe your symptoms

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____ Date _____

Patient name _____

Date _____

For each of the conditions listed below, place a check in the past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the present column

- | | | |
|---|--|--|
| <p>Past Present</p> <ul style="list-style-type: none"> <input type="radio"/> <input type="radio"/> Arthritis <input type="radio"/> <input type="radio"/> Rheumatoid Arthritis <input type="radio"/> <input type="radio"/> Muscular incoordination <input type="radio"/> <input type="radio"/> Visual disturbances <input type="radio"/> <input type="radio"/> Dizziness <input type="radio"/> <input type="radio"/> High blood pressure <input type="radio"/> <input type="radio"/> Heart attack <input type="radio"/> <input type="radio"/> Stroke <input type="radio"/> <input type="radio"/> Systemic lupus <input type="radio"/> <input type="radio"/> HIV/AIDS <input type="radio"/> <input type="radio"/> Allergies <input type="radio"/> <input type="radio"/> Shoulder pain | <p>Past Present</p> <ul style="list-style-type: none"> <input type="radio"/> <input type="radio"/> Angina <input type="radio"/> <input type="radio"/> Kidney stones <input type="radio"/> <input type="radio"/> Kidney disorder <input type="radio"/> <input type="radio"/> Bladder infection <input type="radio"/> <input type="radio"/> Prostate problems <input type="radio"/> <input type="radio"/> Loss of appetite <input type="radio"/> <input type="radio"/> Ulcer <input type="radio"/> <input type="radio"/> Asthma <input type="radio"/> <input type="radio"/> Epilepsy <input type="radio"/> <input type="radio"/> Drug/alcohol dependence <input type="radio"/> <input type="radio"/> Depression <input type="radio"/> <input type="radio"/> Dermatitis/eczema/rash | <p>Past Present</p> <ul style="list-style-type: none"> <input type="radio"/> <input type="radio"/> Chronic sinusitis <input type="radio"/> <input type="radio"/> Diabetes <input type="radio"/> <input type="radio"/> Excessive thirst <input type="radio"/> <input type="radio"/> Frequent urination <input type="radio"/> <input type="radio"/> Smoking/tobacco use Females only <input type="radio"/> <input type="radio"/> Pregnancy <input type="radio"/> <input type="radio"/> Hormone replacement <input type="radio"/> <input type="radio"/> Birth control pills Other health issues <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> |
|---|--|--|

For each of the symptoms listed below, place a check in the present column if you are currently experiencing this symptom.

- | | | |
|--|--|---|
| <p>Present</p> <ul style="list-style-type: none"> <input type="radio"/> Cough <input type="radio"/> Coughing blood <input type="radio"/> Wheezing <input type="radio"/> Chills <input type="radio"/> Heart murmur <input type="radio"/> Chest pain <input type="radio"/> Fainting spells <input type="radio"/> Dizziness <input type="radio"/> Shortness of breath <input type="radio"/> Difficulty laying flat <input type="radio"/> Swelling of the ankles <input type="radio"/> Heartburn/reflux <input type="radio"/> Nausea/vomiting <input type="radio"/> Constipation <input type="radio"/> Changes in bowel movements <input type="radio"/> Diarrhea <input type="radio"/> Jaundice <input type="radio"/> Abdominal pain <input type="radio"/> Black/bloody bowel movements <input type="radio"/> urinary burning/frequency <input type="radio"/> urinary nighttime urgency | <p>Present</p> <ul style="list-style-type: none"> <input type="radio"/> Blood in urine <input type="radio"/> Erectile dysfunction <input type="radio"/> Abnormal urinary discharge <input type="radio"/> Bladder leakage <input type="radio"/> Loss of strength <input type="radio"/> Numbness <input type="radio"/> Headaches <input type="radio"/> Heavy head <input type="radio"/> Tremors <input type="radio"/> Memory loss <input type="radio"/> Joint pain/swelling <input type="radio"/> Stiffness <input type="radio"/> Muscle pain <input type="radio"/> Neck pain <input type="radio"/> Stiff neck <input type="radio"/> Back pain <input type="radio"/> Bruise easily <input type="radio"/> Gums bleed easily <input type="radio"/> Enlarged glands <input type="radio"/> Unusual weight loss/gain <input type="radio"/> Fatigue | <p>Present</p> <ul style="list-style-type: none"> <input type="radio"/> Fever <input type="radio"/> Difficulty hearing <input type="radio"/> Buzzing in ears <input type="radio"/> Ringing in ears <input type="radio"/> Vertigo <input type="radio"/> Sinus trouble <input type="radio"/> Nasal stuffiness <input type="radio"/> Frequent sore throat <input type="radio"/> Loss of hair <input type="radio"/> Heat/cold intolerance <input type="radio"/> Glasses/contacts <input type="radio"/> Eye pain <input type="radio"/> Light-sensitive <input type="radio"/> Double vision <input type="radio"/> Cataracts <input type="radio"/> Anxiety/depression <input type="radio"/> Mood swings <input type="radio"/> Difficulty sleeping <input type="radio"/> Nervousness <input type="radio"/> Tension <input type="radio"/> Skin Rashes/sores/itching |
|--|--|---|

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

- Heart disease Diabetes Cancer Lupus Rheumatoid Arthritis Back/Neck pain

List all prescription and over-the-counter medications, and nutritional supplements you are taking currently:

List all the surgical procedure you have had and times you have been hospitalized:

ANNANDALE FAMILY & SPORTS CHIROPRACTIC, PA
300 Park Street East
Annandale, MN 55302

320.274.3060

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Annandale Family & Sports Chiropractic, PA or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

_____ Patient or Legally Authorized Individual Signature	_____ Date
_____ Print Patient's Full Name	_____ Time
_____ Witness Signature	_____ Date

Consent to Treat a Minor

Minor's Name: _____
(Please print name)

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor ("the minor"), and hereby authorize Annandale Family & Sports Chiropractic, PA to administer treatment as it so deems as necessary to the minor. In the event that the minor has received treatment at your practice previous to the date of this consent form, I hereby authorize such treatment in addition to the treatment mentioned above. I further authorize the minor to complete and sign any documents at Annandale Family & Sports Chiropractic, PA which are customarily completed and signed by patients at your practice as a condition to treatment, and such signature shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form.

Name of Custodial Parent/Legal Guardian: _____
(Please print name)

Relationship to the minor (please circle): Custodial Parent / Legal Guardian

Social Security # of the Parent/Guardian: _____

Date of Birth of the Parent/Guardian: _____

Address of the Parent/Guardian: _____

Home Phone #: _____

Work/Cell #: _____

Signature: _____
Date: ____/____/____

Witness (if any)
Witness' name: _____

Witness' signature _____
Date: ____/____/____

Infant Functional Form (0-1 year old)

Today's Date: _____

Child's Name: _____

Please check all those that apply to your child.

- _____ 1. Has your child been more irritable/less consolable?
- _____ 2. Has your child had difficulty sleeping?
- _____ 3. Has your child's sleeping pattern changed?
- _____ 4. Has your child's digestion pattern changed? (i.e. constipation/diarrhea)
- _____ 5. Has your child intake of food been less or more?
- _____ 6. Has your child needed more parental attention/affection?
- _____ 7. Has your child been more distant/less affectionate?
- _____ 8. Has your child had trouble with nursing or taking a bottle?
- _____ 9. Has your child had a developmental milestone and then lost it? (i.e. able to roll over and now no longer can do so)?
- _____ 10. Has your child shown unwarranted emotions such as fear?
- _____ 11. Has your child shown a new physical issue (i.e. sucking their thumb or blanket) for comfort?
- _____ 12. Has a normal daily activity shown change (i.e. cries now when put in carseat)?
- _____ 13. Have any normal play patterns changed?
- _____ 14. Have you notice any changes in relationships with grandparents/daycare providers?

_____ score

Pediatric Functional Form (Age 1-3):

Today's Date: _____

Child's Name: _____

Please check all that apply to your child.

- _____ 1. Has your child been more irritable?
- _____ 2. Has your child had difficulty sleeping?
- _____ 3. Has your child's sleeping patterns changed?
- _____ 4. Has your child's digestion pattern changed? (i.e. constipation/diarrhea)
- _____ 5. Has your child intake of food been less or more?
- _____ 6. Has your child needed more parental attention/affection?
- _____ 7. Has your child been more distant/less affectionate?
- _____ 8. Has your child had trouble with learning or retaining information?
- _____ 9. Has your child's attention or focus been shortened?
- _____ 10. Has your child's balance or coordination been altered?
- _____ 11. Have you noticed any changes in speech patterns?
- _____ 12. Have you noticed any changes in breathing patterns?
- _____ 13. Have you noticed any visional changes such as squinting?
- _____ 14. Have you noticed a change in "playing" patterns?
- _____ 15. Have you noticed any aggression/violence/acting out?
- _____ 16. Have you noticed any changes in relationships with grandparents/daycare providers/ teachers?

Annandale Family & Sports Chiropractic

300 Park Street East • Annandale, MN 55302 • PH: 320-274-3060 • Fax: 320-274-5605