Power Within Chiropractic of Elk River - Patient Intake Form

Patient Name:_____ Date:_____ Phone (cell/home):_____

Address:_____ City:_____ State:____ Zip Code:_____

Email Address:_____ Sex: M F Marital Status: M S D W Date of Birth:_____

Social Security #:_____ Previous Chiropractic Care? Yes No If yes, when and where?_____

Insurance Comp Name:_____ Policy Holder Name:_____ Policy Holder DOB: ___/___/_____

Your Occupation:_____ Your Employer:_____ Referred by:_____

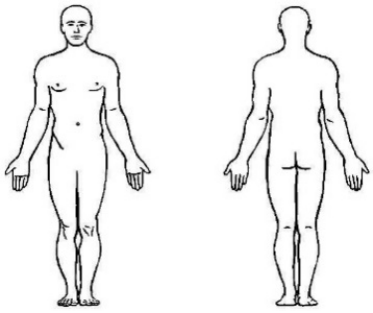
1. Reasons for seeking chiropractic care

Primary Reason: _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  No Pain 0 1 2 3 4 5 6 7 8 9 10 Most Severe
- What percentage of the time do you experience the above symptom?
  0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100%
- When and how did the symptom begin? Suddenly or Gradually?
  _____
- What makes the symptom worse? (circle all that apply):
  bending forward, bending backward, tilting to left, tilting to right, turning head to left, turning head to right, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, most movements, driving, walking, running, nothing, Other (please describe):
  _____
- What makes the symptom better? (circle all that apply): rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe):
  _____
- Describe the quality of the symptom (circle all that apply): sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, numbness, shooting, stinging, Other (please describe):
  _____
- Does the symptom radiate to another part of your body (circle one):
  yes no If yes, where? _____
- Is the symptom worse at certain times of the day or night?
  (circle one): Morning Afternoon Evening Night Unaffected

Secondary Reason: _____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time:
  No Pain 0 1 2 3 4 5 6 7 8 9 10 Most Severe
- What percentage of the time do you experience the above symptom?
  0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100%
- When and how did the symptom begin? Suddenly or Gradually?
  _____
- What makes the symptom worse? (circle all that apply):
  bending forward, bending backward, tilting to left, tilting to right, turning head to left, turning head to right, twisting left at waist, twisting right at waist, sitting, standing, getting up from sitting position, lifting, most movements, driving, walking, running, nothing, Other (please describe):
  _____
- What makes the symptom better? (circle all that apply): rest, ice, heat, stretching, exercise, massage, pain medication, muscle relaxers, nothing, Other (please describe):
  _____
- Describe the quality of the symptom (circle all that apply): sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, numbness, shooting, stinging, Other (please describe):
  _____
- Does the symptom radiate to another part of your body (circle one):
  yes no If yes, where? _____
- Is the symptom worse at certain times of the day or night?
  (circle one): Morning Afternoon Evening Night Unaffected



Please place an X on the body icon where you are feeling your pain and symptoms and then describe any other pertinent information on the right.

_____

_____

_____

_____

Doctor Signature: _____ 1

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Elk River, MN 55330
763.441.3830

Dr. Mychaela Harp Koehler, DC, CCSP®, ICSC
Dr. Mikala Bocan, DC, MS, ATC, CCSP®, ICSC

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Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s): _____

Medications/Supplements: _____

Past Surgeries/Pregnancies and Outcomes/Allergies: _____

Recreational Activities and Lifestyle (hobbies, alcohol, tobacco and drug use, diet): _____

Previous Injury or Trauma: _____

Please indicate if you have a <u>family history</u> of the following conditions or symptoms:

□ Cancer	□ Strokes/TIAs	□ Headaches	□ Cardiac Disease
□ Adopted/Unknown	□ Cardiac Disease below age 40	□ Psychiatric Disorder	□ Neurological Disease
□ Diabetes	□ Other: _____	□ None of the above	

Please indicate if <u>you have</u> a history of any of the following conditions or symptoms:

General

□ Cancer: _____	□ Diabetes	□ Thyroid Disease	□ AIDS/HIV Positive
□ Fatigue	□ Unexplained Weight Loss	□ Decreased Energy	□ Loss of Appetite
□ Night Sweats	□ Excessive Thirst	□ Fever/Chills	□ Skin Ulcers/Rashes
□ Memory Loss	□ Other: _____	□ None of the Above	

Neuromuscular

□ Headaches	□ History of Seizures	□ Stroke/TIAs	□ Arthritis (Unknown)
□ Inflammatory Arthritis: _____	□ Scoliosis	□ Gout	□ Osteoporosis
□ Paralysis	□ Broken Bones: _____	□ Dislocations	□ Difficulty Walking
□ Change in Vision/Smell/Hearing or Taste		□ Other: _____	□ None of the Above

Cardiovascular

□ Heart Attack/MI	□ Pacemaker/Defibrillator	□ Chest Pain/Angina	□ Heart Surgeries
□ Congestive Heart Failure	□ Irregular Heartbeat	□ Peripheral Vascular Disease	□ Shortness of Breath
□ Murmurs or valvular disease	□ Redness or Swelling of Limb	□ Anemia	□ Sickle Cell Anemia
□ High Blood Pressure/Hypertension	□ Regular Aspirin Use	□ Other: _____	□ None of the Above

Respiratory

□ Asthma	□ COPD	□ Wheezing	□ Emphysema
□ Cough/Difficulty Breathing	□ Blood in Sputum	□ Other: _____	□ None of the Above

Gastroenterology

□ Nausea/Vomiting	□ Pain or Difficulty Swallowing	□ Constipation	□ Diarrhea
□ Heartburn/GERD	□ Stomach Pain	□ Hepatitis/Liver Disease	□ Appendectomy
□ Irritable Bowel/Colitis	□ Pancreatitis	□ Gall Stones	□ Ulcers
□ Bloating/Excessive Gas	□ Bloody or Black Tarry Stools	□ Other: _____	□ None of the Above

Genitourinary

□ Kidney Disease/Dialysis	□ Kidney Stones	□ Prostate Enlargement	□ Blood in Urine/Hematuria
□ Burning/Difficulty with Urination	□ Loss of Bladder or Bowel Control	□ Other: _____	□ None of the Above

Psychiatric

□ Anxiety	□ Depression	□ Suicidal Ideations	□ Bipolar Disorder
□ Homicidal Ideations	□ Schizophrenia	□ Change in Mood or Behavior	
□ Other: _____	□ None of the Above		

_____ Initial here if **<u>none</u>** of the listed symptoms or conditions apply to you.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this chiropractic clinic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to Power Within Chiropractic of Elk River, P.A. for services performed.

Patient or Guardian Signature _____ Date_____

Doctor Signature: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that is related to your past, present, or future physical/mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For instance, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Alternatively, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, fund-raising activities, and conduction or arranging for other business activities. For instance, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations may include, as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. For required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____	_____	_____
Patient's Name - Printed	Patient's Signature	Date

Doctor Signature: _____

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INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including examination tests, diagnostic x-rays, physiotherapy, manual/physical techniques, and any supportive therapies performed on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working or associated with, or serving as an agent of Power Within Chiropractic of Elk River, including those staff members employed at the clinic or office listed below or any affiliated office or clinic.

I understand that chiropractic adjustments and supportive treatments are designed to reduce muscle tension, joint restrictions, and improve function allowing the body to return to optimal health. However, as with all healthcare treatments, results are not guaranteed and there is no promise to "cure".

I understand that, as with any health care procedure, there are certain complications that may arise during a chiropractic treatment. Those complications include but are not limited to: fractures, disc injuries, dislocations, and muscle sprains and strains. Although rare, 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. I do not expect the doctor to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) in which the doctor believes, based upon the facts known at the time, are in my best interests.

I understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but are not limited to, self-administered over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and pain killers; physical therapy; steroid injections; bracing; and surgery.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature, purpose, and risks of chiropractic adjustments and other procedures and have had my questions answered to my satisfaction.

If there is any dispute about my care, I agree to resolution by binding arbitration according to the American Arbitration Association guidelines. I have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended.

Having been informed of the risks, I hereby give my consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____	_____	_____
Patient's Name - Printed	Patient's Signature	Date

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Power Within Chiropractic of Elk River to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter: _____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examinations at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

_____	_____	_____
Patient's Name - Printed	Patient's Signature	Date

Doctor Signature: _____

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