

Advanced Spinal Care & Rehab

NEW PATIENT HISTORY & INTAKE FORM

Today's Date _____

Patient Name _____ Date of Birth _____

Phone number _____ Email _____

Address _____

City _____ State _____ Zip _____

(if applicable) Significant other's name _____

(if applicable) Children's name & ages _____

Occupation _____ Employer _____

Have you ever received chiropractic care ___ yes ___ no.

Emergency Contact _____

Relationship _____ Phone Number _____

Name of Medical Doctor _____ clinic _____

I authorize the doctors of Advanced Spinal Care & Rehabilitation and staff to render care as deemed necessary and appropriate for myself and/or my child

I authorize Advanced Spinal Care & Rehabilitation to request my medical records from other providers as necessary for my care.

I authorize Advanced Spinal Care & Rehabilitation to release my medical records to other providers as necessary for my care.

I authorize my insurance benefits (if applicable) directly to Advanced Spinal Care & Rehabilitation Person responsible for this account (if other than patient) _____

I understand that after any promotional services, all care is rendered at usual and customary fees

For the balance of my account my preferred method of payment is ___ cash ___ check ___ credit card ___ insurance (auto, worker's comp, medical/health)

Patient's Signature _____ Today's Date _____

(This represents a long term authorization for all occasions of service)

Advanced Spinal Care & Rehab

NEW PATIENT HISTORY & INTAKE FORM

PRESENT COMPLAINTS

[1] _____ How long has this been an issue _____

How would you describe the pain ___ dull ___ sharp ___ stabbing ___ numb/tingling ___ constant ___ occasional
___ mild ___ moderate ___ severe ___ worse in the morning ___ worse in the evening
___ staying the same ___ getting worse ___ pain radiates to _____

[2] _____ How long has this been an issue _____

How would you describe the pain ___ dull ___ sharp ___ stabbing ___ numb/tingling ___ constant ___ occasional
___ mild ___ moderate ___ severe ___ worse in the morning ___ worse in the evening
___ staying the same ___ getting worse ___ pain radiates to _____

[3] _____ How long has this been an issue _____

How would you describe the pain ___ dull ___ sharp ___ stabbing ___ numb/tingling ___ constant ___ occasional
___ mild ___ moderate ___ severe ___ worse in the morning ___ worse in the evening
___ staying the same ___ getting worse ___ pain radiates to _____

[4] _____ How long has this been an issue _____

How would you describe the pain ___ dull ___ sharp ___ stabbing ___ numb/tingling ___ constant ___ occasional
___ mild ___ moderate ___ severe ___ worse in the morning ___ worse in the evening
___ staying the same ___ getting worse ___ pain radiates to _____

Does your current complaint affect your ___ sleep ___ work ___ daily routine ___ sitting ___ driving

What makes your symptoms feel better _____

What makes your symptoms worse _____

What types of doctors have you seen for your present condition _____

What types of treatments have you received _____

Did these treatments ___ improve or ___ worsen your symptoms?

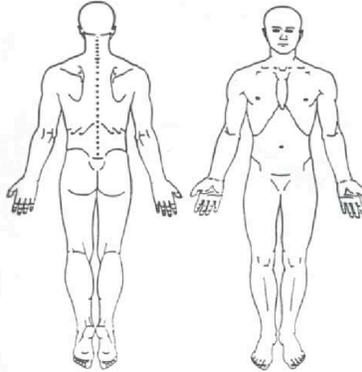
(if applicable) Are you currently pregnant ___ yes ___ no.

Additional notes _____

Advanced Spinal Care & Rehab

NEW PATIENT HISTORY & INTAKE FORM

Please mark any and all areas of concern:



HEALTH HISTORY (please check any and all that apply)

PAST - PRESENT

- | | | |
|---|---|--|
| <input type="checkbox"/> <input type="checkbox"/> headaches | <input type="checkbox"/> <input type="checkbox"/> sleeping problems | <input type="checkbox"/> <input type="checkbox"/> depression |
| <input type="checkbox"/> <input type="checkbox"/> migraines | <input type="checkbox"/> <input type="checkbox"/> vision problems | <input type="checkbox"/> <input type="checkbox"/> alcohol use |
| <input type="checkbox"/> <input type="checkbox"/> shortness of breath | <input type="checkbox"/> <input type="checkbox"/> thyroid problems | <input type="checkbox"/> <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> <input type="checkbox"/> allergies / asthma | <input type="checkbox"/> <input type="checkbox"/> liver disease | <input type="checkbox"/> <input type="checkbox"/> low blood pressure |
| <input type="checkbox"/> <input type="checkbox"/> medication side effects | <input type="checkbox"/> <input type="checkbox"/> kidney problems | <input type="checkbox"/> <input type="checkbox"/> history of stroke |
| <input type="checkbox"/> <input type="checkbox"/> diabetes | <input type="checkbox"/> <input type="checkbox"/> light sensitivity | <input type="checkbox"/> <input type="checkbox"/> high cholesterol |
| <input type="checkbox"/> <input type="checkbox"/> cold hands or feet | <input type="checkbox"/> <input type="checkbox"/> urinary problems | <input type="checkbox"/> <input type="checkbox"/> TMJ |
| <input type="checkbox"/> <input type="checkbox"/> muscles aches | <input type="checkbox"/> <input type="checkbox"/> easily bruised | <input type="checkbox"/> <input type="checkbox"/> digestive issues |
| <input type="checkbox"/> <input type="checkbox"/> trouble walking | <input type="checkbox"/> <input type="checkbox"/> tobacco use | <input type="checkbox"/> <input type="checkbox"/> pain all over |
| <input type="checkbox"/> <input type="checkbox"/> leg/foot numbness | <input type="checkbox"/> <input type="checkbox"/> dental problems | <input type="checkbox"/> <input type="checkbox"/> tension/irritability |
| <input type="checkbox"/> <input type="checkbox"/> fainting | <input type="checkbox"/> <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> <input type="checkbox"/> chest pain |
| <input type="checkbox"/> <input type="checkbox"/> gall bladder troubles | <input type="checkbox"/> <input type="checkbox"/> blood thinner use | <input type="checkbox"/> <input type="checkbox"/> pacemaker |
| <input type="checkbox"/> <input type="checkbox"/> ringing in the ears | <input type="checkbox"/> <input type="checkbox"/> HIV positive | <input type="checkbox"/> <input type="checkbox"/> heart problems |
| <input type="checkbox"/> <input type="checkbox"/> ear problems | <input type="checkbox"/> <input type="checkbox"/> cancer | <input type="checkbox"/> <input type="checkbox"/> arrhythmia |
| <input type="checkbox"/> other _____ | | |

List any and all medications you are currently taking _____

Has any doctor or other health professional advised you to "Go see a Chiropractor" ___ yes ___ no.

List any past injuries (auto collisions, falls, work or sports injuries) _____

List any and all care received for the above injuries _____

List any and all past hospitalizations or surgeries _____

Joanna Prokes, DC

4535 Hodgson Rd #200, Shoreview, MN 651-490-1507 www.advancedspinal.net

Advanced Spinal Care & Rehab

NEW PATIENT HISTORY & INTAKE FORM

FAMILY HISTORY

Mother's side ___ heart disease ___ cancer ___ diabetes ___ heavy medication use ___ arthritis ___ other

Father's side ___ heart disease ___ cancer ___ diabetes ___ heavy medication use ___ arthritis ___ other

Any additional family history of note _____

CONSENT FOR THE PURPOSE OF TREATMENT, PAYMENTS and HEALTHCARE OPERATIONS

In this document, "I" and "My" refers to the patient and "Chiropractic" and "Provider" refers to **Advanced Spinal Care & Rehab**

I consent to the use or disclosure of my protected health information by the chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my healthcare bill or to conduct healthcare operations of my provider. I understand that analysis, diagnosis or treatment of me by the chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used for disclosure to carry out treatment, payment or healthcare operations of the practice. The chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has acted in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition.

The nature of the chiropractic adjustment

The primary treatment used at this chiropractic office is spinal manipulative therapy. However, we also use a machine called a Proadjuster to perform spinal adjustments as well. The treatment most beneficial to you will be recommended by your chiropractic provider. Common side effects and risks may apply from receiving chiropractic treatments, such as soreness, aching or stiffness. These side effects typically last for only a few days and/or treatments. Please speak directly with your chiropractic provider if you have specific inquiries or concerns.

Notice of Privacy (HIPAA)

I understand that I have a right to receive a Notice of Privacy prior to signing this document. This Notice of Privacy describes the types, uses and disclosures of my protected health information that may occur during my treatment, payment of bills or in the performance of the healthcare operations of the chiropractor. The notice of privacy practices is available in the waiting area in the office of **4535 Hodgson Road Suite 200 Shoreview, MN 55126**. Privacy practices are subject to change and you may obtain an updated copy at any time by calling our office and requesting one.

Signature of Patient (or legal guardian if under 18) _____

Printed Name of Patient (or legal guardian if under 18) _____

page 4 of 4

Joanna Prokes, DC

4535 Hodgson Rd #200, Shoreview, MN 651-490-1507 www.advancedspinal.net