Take Care
CHIROPRACTIC & WELLNESS

WELCOME! We are glad that you have chosen us to help you achieve optimal health & wellness!

Today is your New Patient Introductory visit, which includes:

- Meeting the Doctor & the Team
- A Thorough Health Consultation
- A unique and highly accurate neurological and spinal examination as well as some specific pictures of your spine (if necessary) to determine whether or not you are eligible for care in this office.

At the end of today's visit, you will be scheduling a follow-up report with the Doctor.
During your *Report of Exam Findings,* we will discuss your test results from today's visit and give you your first *chiropractic adjustment (if your condition warrants). You will also receive the doctor's best recommendations for your care and discuss the most cost-effective and affordable ways for you to benefit from our advanced wellness care. We strongly encourage you to bring your spouse/significant other so that they have a complete understanding of your exam results and the recommendations that are being made.

* First adjustment is **not included** in your New Patient Introductory investment.

This report takes approximately 45-60 minutes. However, we ask that you allow for 60 minutes just in case. We will give you time options and will work to accommodate your availability. **Although we are a Family Practice, we kindly request that you arrange for childcare during your Doctor's Reports.**

You may be getting the feeling that we do things a "little" differently around here, *but isn't that why you came*?
We are very confident with the quality of care and service we provide, and we are proud of the positive impact we have been able to make in the lives of our Practice Members. We look forward to the possibility of being of service and ultimately empowering you to achieve maximum life potential, the way Chiropractic Care has for so many others.

Enjoy today's visit with us…many people tell us that it forever changed their lives!

I have read and understand the information presented:

____ _________________________
Signature of New Patient Date

____ _________________________
Received by a Take Care Team Member Date

www.takecarechiro.com.com
info@takecarechiro.com
120 s. 6th Street, Skyway Suite 225 ■ Minneapolis, MN 55402
Main: 612.746.5555 ■ Fax: 612.746.5554

PATIENT APPLICATION FOR CARE

Today's Date__________________

Please read and complete this questionnaire <u>in detail</u>. *Do not leave any blank questions, simply put NA if a question does not apply to you. Your answers will help us determine if chiropractic care can assist you. If we do not believe your condition will respond, we will not accept your case and make a recommendation that better suits your health needs.*

A caring family member, friend or coworker refers most patients to our office. Whom may we thank for referring you today?
____

PERSONAL INFORMATION

Name: First ________________________MI ______Last ____
How would you like to be addressed? ____
Address: ____City: ________________________State: ______Zip:_____________
Home Phone: _____________________ Work Phone: ____________________ Cell Phone: ______________________________
E-Mail Address:_______________________________ DOB: ____/____/____ Age: _______
Occupation: _________________________________ Employer: _________________
Marital Status: S M W D Significant Other's Name: _________________________
Emergency contact: __________________________ Phone:_________________
Children's Name & Ages:____

HEALTH HISTORY

Have you ever had Chiropractic Care? ____ Y ____ N How long has it been? ____
Have any members of your family received Chiropractic Care? ____ Y ____ N Who? ______________________________
Research shows that your spine should be checked regularly. When was your last spinal examination, including x-rays?
____
What is the purpose/reason for this appointment?____
How often do you drink alcoholic beverages? __________________ Do you smoke? ____ Y ____ N How much? ______________
Do you exercise? ____ Y ____ N How often? ____________________________ What type? ________________________________
Do you have any allergies? (specify) ____
Have you ***ever*** suffered from or been diagnosed as having: (check all that apply)

____ Cancer
____ Broken or fractured bones
____ Osteoarthritis
____ Eating Disorder
____ Circulatory Problems
____ Epilepsy
____ Alcoholism
____ Strokes
____ HIV Positive
____ Gall Bladder Attacks
____ A Congenital Disease
____ Seizures/Convulsions
____ Excessive Bleeding
____ Ulcers
____ Pacemaker
____ TMJ/Head problems
____ Rheumatoid Arthritis
____ Trouble Sleeping
____ Depression
____ High/Low Blood Press.
____ Coughing Blood
____ Tumors
____ Drug Addiction
____ Diabetes

If yes, please explain____
Have you ever been hospitalized? ____ Y ____ N If yes, please explain____
Have you ever had surgery? ____ Y ____ N If yes, please explain____
When was your last physical exam? ________________ By whom? ____
When was the last time you were involved in an accident of any kind? ____

Do you ever take Over the Counter Medicine? ____ Y ____ N
What type/s____________________________________
How long? ____________________________________
How much? ____________________________________

Do you ever take Prescription Medicine? ____ Y ____ N
What type/s____
How long? ____
How much? ____

Do you ever take Supplements? ____ Y ____ N
What type/s____________________________________
How long? ____________________________________
How much? ____________________________________

Do you ever take anything else? ____ Y ____ N
What type/s____
How long? ____
How much? ____

SYSTEMS REVIEW

In the *left hand* column, please indicate with a:
(C) Conditions that you have **NOW** or with a **(P)** Conditions you have **HAD IN THE PAST** or with a **(NA)** for **neither apply**.

____High Blood Pressure
____Dizziness/Fainting
____Insomnia
____Low Resistance to Illness
____Tension
____Confusion
____Fatigue
____Ulcers
____Eye/Vision Problems
____Ear/Hearing Problems
____Difficulty Breathing
____Heart Problems
____Constipation
____Diarrhea
____Digestion Problems
____Nausea
____Female Problems
____Prostate Problems
____Diabetes
____Loss of Memory
____Hands/Feet cold
____Sweaty Palms
____Hand Tremors/Pain
____Anxiety
____Depression
____Irritability
____ Jaw pain
____ Headaches

FOR DOCTOR'S USE ONLY

Dr. Reviewed system **Body Signals**

____General……………Weight changes, fatigue, anorexia, fever, chills, changes in activity

____Skin…………………Rashes, changes in warts/moles/pigmentation, itching, bruising, hair loss

____Head………………Trauma, headaches, dizziness, light headed

____Eyes…………………Change in vision, blurred, redness, scotomata pain, excessive lacrimation

____Nose ………………Rhinorrhea, epistaxis, allergies, airway obstruction

____Mouth/Throat…….Ulcers, tooth pain, TMJ, gum bleeding, soreness, enlarged glands, strep

____Neck ………………Stiffness, lumps, swelling, masses, pain

____Lungs………………Cough, hemoptysis, dyspnea, pain, wheezing, night sweats

____Cardiac……………Palpitations, chest pain, orthopnea, nocturnal dyspnea, ankle swelling, fainting

____Vascular………….Raynaud's phenom, intermittent claudication, hypertension, rheumatic fever

____Breasts……………Self-exam frequency/results, pain, discharge, lumps/masses, skin dimpling

____Gastrointestinal…..Unusual diet, dyspepsia, nausea, vomiting, abdominal pain, cramps,
………………………… hematemasis, bowel irregularity, jaundice, abdominal swelling

____Genitournary…….Polyuria, nocturia, oliguria, dysuria, urgency, heaturia, STD, scrotal mass,
…………………………dysparounia, hernia

____Endrocrine………..Polydipsia, polyphagia, tremors, temp intolerance, goiter, alopecia, hirsutism,
…………………………menstruation, pregnancy history, dysmeorrhea, PMS, climacteric

____Hematopoietic…..Anemia, abdominal bleeding, lymph node enlargement/pain

____Muscoskeletal…Bone/joint pain, swelling, joint deformity, trauma, restricted ROM, weak, atrophy

____Neurological…Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, staxis,
…………………………loss of balance, numbness, paresthesia

____Psychological…Mood swings, depression, anxiety, phobias

☐ RECORDS REQUEST NEEDED

Notes____

____

PROVIDER LIST

Please identify all facilities/providers you have seen for these conditions and those who you are currently seeing, if any, for your presenting condition(s).

Dr. Name/Facility____________________________________ Condition____
Type of treatment received____________________________ From when to when________________________________
Dr. Name/Facility____________________________________ Condition____
Type of treatment received____________________________ From when to when________________________________
Dr. Name/Facility____________________________________ Condition____
Type of treatment received____________________________ From when to when________________________________

PATIENT HISTORY

What is your main complaint?____

How long have you been experiencing your main complaint?_________________

On the scale below, please indicate the severity of your main complaint ***at is worst***:

None		Slight		Mild		Moderate		Severe	
1	2	3	4	5	6	7	8	9	10

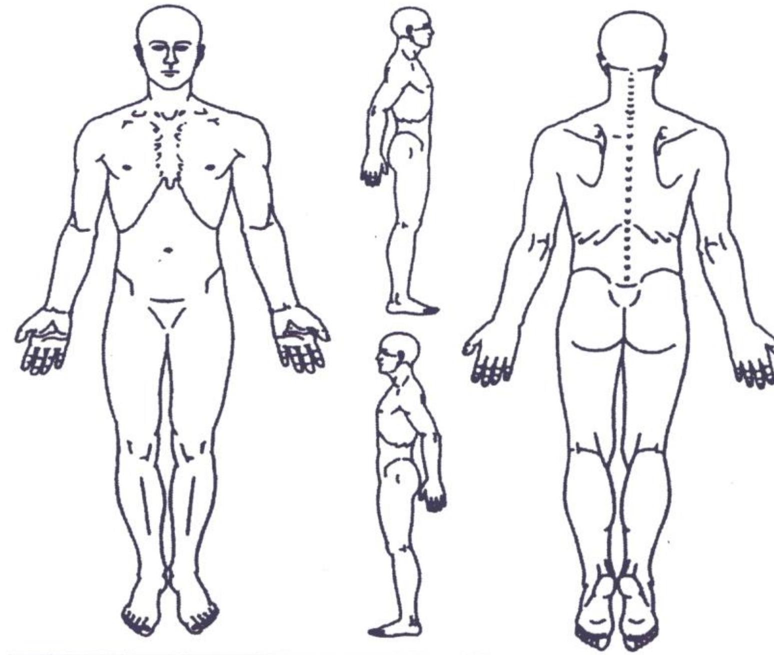
On the scale below, please indicate the ***percentage of the time*** you experience your main complaint:

		Occasional		Intermittent			Frequent		Constant	
0	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

On the diagram below, please show where you are experiencing any or all of your present complaints using the following:

A: Ache **B**: Burning pain **C**: Cramping **D**: Dull pain **R**: Throbbing pain **N**: Numbness **T**: Tingling

(complete this section once you have printed these forms)



When do you notice it the most? ____ AM ____ PM How long does it last?_______Minutes _______Hours ______Days

What makes it feel better? ______________________ What makes it feel worse?___________________________________

Have you had this problem in the past? ____ Y ____ N Have you ever received care for this problem in the past? ____ Y ____ N

Have you lost time from work because of it? ____ Y ____ N If yes, by whom? ___________________________________

Do you have pain and/or difficulty performing any of the following activities:

____ Personal Care *(i.e. changing clothes)*
____ Work
____ Walking *(i.e. unable to go distance)*
____ Lifting *(i.e. carrying your child)*
____ Sitting *(i.e. creates discomfort)*
____ Standing *(i.e. creates discomfort)*
____ Reading *(i.e. causes headaches)*
____ Sleeping *(i.e. sleeplessness due to pain)*
____ Social Life *(i.e. dancing, sports*
____ Concentrating *(i.e. difficulty focusing)*
____ Recreation *(i.e. playing sports)*

Female Patients:

First day of your menstrual cycle? ________ Are you pregnant? ____ Y ____ N # of pregnancies? _____ Miscarriages? _______

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Consent for purposes of treatment, payment and healthcare operations

I consent to the use of my protected health information by Take Care Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or conduct health care operations of Take Care Chiropractic.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand Take Care Chiropractic will prepare any necessary reports and forms to make collections from the insurance company and that any amount authorized to be paid will be directly to Take Care Chiropractic. However, I clearly understand and agree that all services rendered will be immediately due and payable. I agree that

I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account.
The fee for X-Rays is for analysis only. The film is the property of Take Care Chiropractic. Once films are used for treatment purposes, they cannot be released without proper written request. A fee for X-Ray copying will apply. There will be a fee to expedite records request within one week of your consultation.

Healthcare Operations

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

The nature of chiropractic treatment: The doctor will use his hands and/or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel a movement in the joint. Various ancillary procedures such as cold packs, muscle stimulation, or active physical rehabilitation may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. PLEASE ASK YOUR DOCTOR TO EXPLAIN THE TECHNIQUE AND/OR EXTRA SAFEGUARDS PRACTICED TO ENSURE SUCH HAPPENINGS DO NOT OCCUR. A minority of patients may notice stiffness or soreness in the beginning of care. The risks of complications due to chiropractic treatment have been described as "rare". The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare."

Risks of remaining untreated: allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatement will complicate the condition and make future rehabilitation more difficult.

I have read and fully understand the above statements. I have freely decided to undergo this consult, and hereby give my full consent.

______________________________ __________________________________

Signature Date

Consent Form

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I acknowledge that Take Care Chiropractic is HIPAA Compliant and will not sell or give away any of my personal information without my consent. I may request a copy of the Notice of Privacy Practices at any time. I further understand that this Notice may be modified with no prior notification to me and that the most recent version of this Notice will be posted in the patient area of Take Care Chiropractic.

I understand the information presented and I may request a copy of the Notice of Privacy Practices:

____ _________________________
Signature of New Patient Date

____ _________________________
Received by a Take Care Team Member Date

Privacy Policy Form

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Out-of-Network Insurance Verification Form

We are out-of-network with **ALL** insurance providers. However, we will bill to ***any and all*** insurance companies. If we can bill directly to your insurance provider is dependent upon what you have for out-of-network participation. To find out what, if any, participation you have, call your provider and get the following 5 questions answered, then bring this completed form with you to your initial appointment:

Date: _______________

Name: ____

Insurance Provider: _______________________________

ID #: _________________________________ Group #: ___________________

What to Ask Your Insurance Provider: (Be sure to indicate you are seeking **OUT-OF-NETWORK** benefits)

1. Is this a calendar year plan? _____ Yes _____ No
   If no, what is the fiscal year for your plan: _______________ to _______________
2. What is your Deductible: $______________________
   What if any has been met for the current year: $______________________
3. What is your co-insurance or co-pay responsibility: _____________________________
4. Is there a visit limit?
   If so, how many allowed visits allowed within your calendar plan? __________________
5. Do the in-network and out-of-network deductibles cross apply? Yes ______ No _______
   "Is my deductible the same whether I see a provider in network or out-of-network?"

We will include any estimated insurance participation in your care plan recommendation and/or discuss with you further your options and the best way to utilize any insurance participation you have.

Please do not hesitate to let us know if you have any questions or concerns -- we are here to help!

INS Verification Form

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