Patient Information

Name: _____
First MI Last

Nickname I prefer: _____

Address: _____
City: _____
State: _____ **Zip code**: _____

SS#: _____ - _____ - _____

Sex: ☐ Male ☐ Female

Primary Language: ☐ English ☐ Other: _____

Race: ☐ White ☐ Black ☐ Asian ☐ Latino ☐ Other

Birth Date: _____/_____/_____
Month Day Year

Occupation: _____
Employer: _____

Marital Status: ☐ Single ☐ Married
☐ Divorced ☐ Widowed ☐ Separated

Spouses Name: _____

Home Phone #: (_____) _____

Cell Phone #: (_____) _____

Work Phone #: (_____) _____

Email (H): _____@_____
Email (W): _____@_____

My Preferred Method of Phone Contact:
Primary: ☐ Home ☐ work ☐ cell
Secondary: ☐ Home ☐ work ☐ cell

How were you referred to or found our office?
☐ Patient: _____
☐ Insurance ☐ Physician ☐ Therapist
☐ Website ☐ Sign ☐ Ads
☐ Yellow pages ☐ _____

Emergency Contact: _____
Contact Phone #: (_____) _____

Financial/Insurance Information

Payment Type: ☐ Cash ☐ Insurance

Person financially responsible for your account?
☐ Self ☐ Spouse ☐Parent
☐ Other: _____

Insurance Carrier: _____
Policy Holder: ☐ Self ☐ Spouse ☐ Parent
☐ Other: _____
Policy Holders Birth date: ____/____/_____
Policy Holders Name:_____

Office Communication Preferences

I give the office permission to communicate scheduled appointment reminders, missed appointment notifications, and reminders to reschedule recommended care using the following methods: Text messaging, Cell Phone, Home Email, Work Email.
If you do not want to use any one of these forms of communications, opt out by listing them below:
_____

Patient Signature: _____ **Date:** _____
Parent/Guardian Signature: _____ **Date**: _____

Crosstown Clinic of Chiropractic, 2330 Crosstown Blvd NE, Ham Lake, MN 55304, (763-434-5714)

Health Questionnaire

(Current Condition)

Name: _____

Describe your symptoms: _____

_____

When did your symptoms start? _____

How did your symptoms start? _____

_____

_____

_____

How are your symptoms changing?

☐ Better ☐ Not changed ☐ Worse

Describe your symptoms?

☐ Sharp ☐ Dull ☐ Achy ☐ Stiff
☐ Burning ☐ Throbbing
☐ Other: _____

Describe the average intensity of your symptoms:

☐ Mild ☐ Moderate ☐ Severe

How often are your symptoms:

☐ Constant ☐ Frequent ☐Intermittent
☐ Occasional ☐ Other: _____

When are your symptoms worse?

☐ No change ☐ As day progresses
☐ Mornings ☐ Afternoon
☐ Evenings ☐ Sleeping
☐ Other: _____

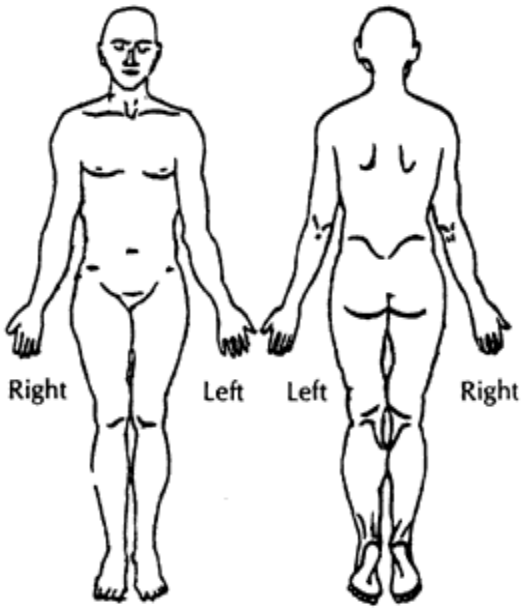
When are your symptoms better?

☐ No change ☐ As day progresses
☐ Mornings ☐ Afternoon
☐ Evenings ☐ Sleeping
☐ Other: _____

What activities aggravate your symptoms?

☐ Nothing ☐ Walking ☐ Standing
☐ Resting ☐ Movement ☐ Sleeping
☐ Bending ☐ Turning ☐ Lifting
☐ Other: _____

Mark on the figures below where your symptoms are located:



What activities improve your symptoms?

☐ Nothing ☐ Walking ☐ Standing
☐ Resting ☐ Movement ☐ Sleeping
☐ Bending ☐ Turning ☐ Lifting
☐ Other: _____

Do any of the following give you temporary relief?

☐ Ice ☐ Heat ☐ Medication
☐ Other: _____

Who have you seen for your current symptoms?

☐ No one
☐ Another Chiropractor
☐ Medical Doctor
☐ Physical therapist
☐ Other: _____

Have you had similar symptoms in the past?

☐ Yes ☐ No When? _____

Who did you see for treatment in the past?

☐ No one
☐ This office
☐ Another Chiropractor
☐ Medical Doctor
☐ Physical therapist
☐ Other: _____

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date**: _____

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Name: _____
Height: _____ feet, _____ inches
Weight: _____ pounds

Office Use Only
BP: _____ / _____, Pulse _____
Respiration: ____, Temp.: _____

Smoking history:
☐ Never ☐ Former ☐ Current

Alcohol usage:
☐ None ☐ Casual
☐ Moderate ☐ Heavy

Caffeinated drinks a day:
☐ None ☐ Less than 3
☐ 3-6 ☐ More than 6

Exercise habits:
☐ Never ☐ Daily ☐ Weekly

List any prescription and over the counter medications you are currently taking:

_____ _____ _____ _____
_____ _____ _____ _____

List any nutritional/herbal supplements you are taking:

_____ _____ _____ _____

List all allergies to medications:

_____ _____ _____ _____

List any immediate family members whom have had any of the following health conditions:

Back problems: ☐ Mom ☐ Dad ☐ Brother ☐ Sister ☐ Grandfather (F/M) ☐ Grandmother (F/M)
Cancer: ☐ Mom ☐ Dad ☐ Brother ☐ Sister ☐ Grandfather (F/M) ☐ Grandmother (F/M)
Heart disease: ☐ Mom ☐ Dad ☐ Brother ☐ Sister ☐ Grandfather (F/M) ☐ Grandmother (F/M)
Diabetes: ☐ Mom ☐ Dad ☐ Brother ☐ Sister ☐ Grandfather (F/M) ☐ Grandmother (F/M)
Other: _____ ☐ Mom ☐ Dad ☐ Brother ☐ Sister ☐ Grandfather (F/M) ☐ Grandmother (F/M)

List any major injuries, hospitalizations and surgical procedures:

_____ _____ _____ _____
_____ _____ _____ _____

Please check off any health conditions which apply to you:

Past	Present	Musculoskeletal	Past	Present	Medical
○	○	Headaches	○	○	Cancer
○	○	Neck pain	○	○	Diabetes
○	○	Upper back pain	○	○	Vascular disease
○	○	Mid back pain	○	○	Heart attack
○	○	Low back pain	○	○	Chest pain
○	○	Shoulder pain	○	○	Stroke
○	○	Elbow/Upper arm pain	○	○	High blood pressure
○	○	Wrist pain	○	○	Ulcers/Stomach pain
○	○	Hand pain	○	○	Respiratory disease
○	○	Hip/Upper leg pain	○	○	Liver disease/Gall bladder
○	○	Knee/Lower leg pain	○	○	Kidney disease/Stones
○	○	Ankle/Foot pain	○	○	Pancreas disease
○	○	Disc disease/Bulge/Herniation	○	○	Bladder problems
○	○	Fibromyalgia	○	○	Prostate disease/cancer (Male)
○	○	Degenerative arthritis	○	○	Drug/Alcohol dependency
○	○	Rheumatoid arthritis	○	○	Hepatitis
○	○	Joint replacement	○	○	Hormone replacement (Female/Male)
○	○	Muscle weakness	○	○	Pregnancy (Female)
○	○	Muscular disease _____	○	○	Birth control (Female)
○	○	Neurologic disorder _____	○	○	Other _____

Patient Signature: _____ **Date:** _____
Parent/Guardian Signature: _____ **Date**: _____

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Treatment and Financial Agreements

Consent For Treatment: I authorize Valorie Hoffmann DC, Robert Hoffmann DC and whomever they may designate as their assistant(s) to administer treatment as they deem necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

Authorization to Release Medical Information: I authorize the release of any medical information to process my insurance claims and certify that all insurance information is correct and complete. I will notify the office of any changes in my health coverage.

Request for Payment of Benefits to Provider of Care: I authorize my insurance company to pay Robert C. Hoffmann DC (DBA: Crosstown Clinic of Chiropractic) for any benefits allowable under my insurance policy, as payment toward the total charges for service rendered and have agreed to pay, in a timely manner, any balance of said claim.

Guarantee of Account: I will promptly notify the office of any changes in my medical condition/health status. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me I making collection from my insurance company and that any amount paid directly to this office will be credited to my account upon receipt. I permit this office to endorse checks on my behalf for any and all drafts for payment of my bill. However, I clearly understand that I am personally responsible for all charges to my account, including, but is not limited to, copayments, deductibles, non-covered services and finance charges.

Person to Person Communication: To help with my coordination of care and or billing, the Doctor's and clinic staff may share information with the following people I authorize:

_____	_____	_____
First name, last name	relationship to me	best contact number
_____	_____	_____
First name, last name	relationship to me	best contact number

Acknowledgement and Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health information:
The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

I understand the following: This form does not expire. If I change the information on this form, I will fill out a new form.

Patient Signature: _____ **Date:** _____
Parent/Guardian Signature: _____ **Date**: _____

Consent for Treatment of a Minor or Persons under Legal Guardianship: I hereby authorize Valorie Hoffmann DC, and or Robert Hoffmann DC and whomever they may designate as their assistant(s) to administer treatment as they deem necessary to:

_____	_____
Patient's name	Relationship to patient

Parent/Guardian Signature: _____ **Date**: _____

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