Patient Information

Name: ___________________________________
First MI Last

Nickname I prefer: ____________________________

Address: ________________________________

City: ___________________________________

State: ____________ **Zip code:** _______________

Social: ________-_______-___________

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 Chiropractic, PA, 2330 Crosstown Blvd NE Suite A, 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

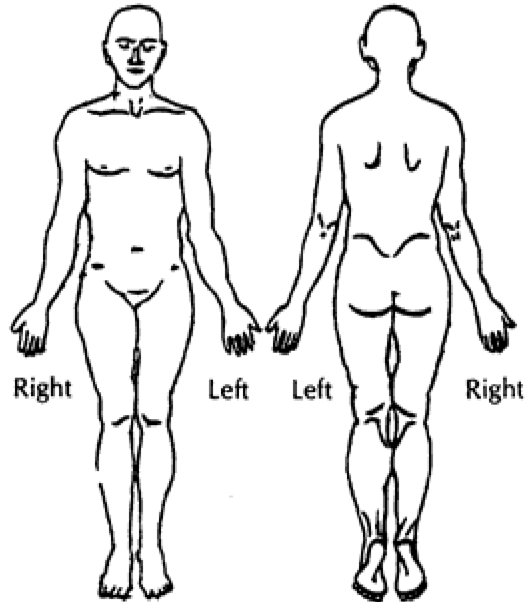
How often are your symptoms:
☐ Constant ☐ Frequent ☐Intermittent
☐ Occasional ☐ Other: ________________

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
○	○	Headaches
○	○	Neck pain
○	○	Upper back pain
○	○	Mid back pain
○	○	Low back pain
○	○	Shoulder pain
○	○	Elbow/Upper arm pain
○	○	Wrist pain
○	○	Hand pain
○	○	Hip/Upper leg pain
○	○	Knee/Lower leg pain
○	○	Ankle/Foot pain
○	○	Disc disease/Bulge/Herniation
○	○	Fibromyalgia
○	○	Degenerative arthritis
○	○	Rheumatoid arthritis
○	○	Joint replacement
○	○	Muscle weakness
○	○	Muscular disease ___________________
○	○	Neurologic disorder _________________

Past	Present	Medical
○	○	Cancer
○	○	Diabetes
○	○	Vascular disease
○	○	Heart attack
○	○	Chest pain
○	○	Stroke
○	○	High blood pressure
○	○	Ulcers/Stomach pain
○	○	Respiratory disease
○	○	Liver disease/Gall bladder
○	○	Kidney disease/Stones
○	○	Pancreas disease
○	○	Bladder problems
○	○	Prostate disease/cancer (Male)
○	○	Drug/Alcohol dependency
○	○	Hepatitis
○	○	Hormone replacement (Female/Male)
○	○	Pregnancy (Female)
○	○	Birth control (Female)
○	○	Other ____________________________

Patient Signature: ____________________________________ **Date:** _______________
Parent/Guardian Signature: _____________________________ **Date**: _______________

Treatment and Financial Agreements

Consent For Treatment: I authorize Mackenzie Engelstad DC, Logan Engelstad 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 Mackenzie Engelstad DC, Logan Engelstad DC (DBA: Crosstown Clinic PA) 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 Mackenzie Engelstad DC and/or Logan Engelstad 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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Informed Consent

I hereby authorize physicians and staff at Crosstown Chiropractic, PA to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff at Crosstown Chiropractic, PA responsible for any errors or omissions that I may have made at completion of this form.

Chiropractic and all other types of health care are associated with potential risks in treatment delivery. Therefore, it is necessary to inform the patient of such risk prior to initialing care. While chiropractic treatment is remarkedly safe, you need to be informed about potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any other health care system, we cannot promise a cure for any symptoms, conditions, or diseases as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific risk possibilities associated with chiropractic care:

Soreness – Chiropractic adjustments and physical therapy techniques are sometimes accompanied by post treatment soreness. This is a normal response to chiropractic and physical therapy treatment. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury – Chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon, or other soft tissue injury.

Rib Injury – Manual adjustments to the thoracic spine, in rare cases, may cause a rib injury or fracture. A thorough health history or x-rays will be taken before treatment to minimize such risk.

Physical Therapy Burns – Heat generated by physical therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, please report it to your doctor or staff member.

Stroke – Stroke is the most serious complication of chiropractic treatment. A thorough medical history will take place before any manual manipulation of the head or neck. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems – There are occasionally other types of side effects associated with chiropractic care, while these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read above, I hereby give informed consent to have chiropractic treatment administered.

Patient Signature: ________________________ **Date:**____________

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