H

HERING CHIROPRACTIC

969 Old Highway 8 NW, Suite 100
New Brighton, MN 55112
(651)-287-3035

Personal Information

NAME _____SOCIAL SECURITY # _____ - _____ - _____

ADDRESS_____

CITY/STATE/ZIP_____

HOME PHONE _____ WORK PHONE _____

CELL _____ EMAIL ADDRESS _____

GENDER (circle) M F BIRTH DATE _____ AGE _____

OCCUPATION_____

BEST TIME TO CONTACT YOU _____ MARITAL STATUS (circle) S M D W

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

_____

FAMILY MEDICAL DOCTOR _____

MEDICAL OFFICE ADDRESS _____

Your Health Profile

At HERING CHIROPRACTIC, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological/emotional stresses, which can accumulate and result in serious loss of health potential. Most of the time, these effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses you face – past and present – and allow us to better assess the challenges to your health potential. If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the “General History” section on page 3.

Please describe your CHIEF CONCERN and the effect it has had on your life.

_____
_____
_____

List your health concerns, according to severity:	Rate of severity 1=mild 10=worst	When did the episode begin?	Did the problem begin with an injury?	Are symptoms consistent or intermittent?
1.				
2.				
3.				
4.				
5.				
6.				
7.				

If you are experiencing pain, is it one of the following types? ____ Sharp ____ Dull Ache

Does the pain travel/radiate anywhere? ____ No _____Yes (please describe)

_____

Since the problem began, it is ____About the Same ____Getting Better ____Getting Worse

What makes it worse?_____

What have you done for the condition that has helped you feel better? _____

_____

What have you done for the condition that was of no help? _____

_____

Do you have a family history of this or similar symptoms?_____

How does this condition interfere with your life? _____

_____

Who have you seen for this condition? ____Chiropractor ____Medical Doctor ____Other

1. Name/Address _____ Date _____

   What was the diagnosis? _____

   What was done? _____

1. Name/Address_____ Date _____

   What was the diagnosis? _____

   What was done? _____

General History

Check all symptoms you have ever experienced, even if they do not seem to be related to your current problem:

___Headaches	___Pins/needles in legs	___Neck pain	___Urinary problems
___Pins/needles in arms	___Loss of smell	___Back pain	___Loss of balance
___Buzzing in ears	___Diarrhea	___Dizziness	___Nervousness
___Numbness in fingers	___Numbness in toes	___Loss of taste	___Stomach upset
___Menstrual irregularity	___Depression	___Irritability	___Tension
___Sleeping problems	___Stiff neck	___Cold hands	___Cold feet
___Ringing in ears	___Constipation	___Fever	___Hot flashes
___Cold sweats	___Lights bother eyes	___Fainting	___Ulcers
___Mood swings	___Menstrual pain	___Fatigue	___Heartburn

List any medications that you are taking and why **(prescription and NON-prescription).**

_____

_____

_____

_____

Have you ever had surgery? (Please include all surgeries.)

1. Type _____ Date _____ Doctor _____

2. Type _____ Date _____ Doctor _____

3. Type _____ Date _____ Doctor _____

4. Type _____ Date _____ Doctor _____

Accidents and/or injuries: auto, work related, or others – especially those related to your current problems:

1. Type _____ Date _____ Hospitalized: Yes or No

2. Type _____ Date _____ Hospitalized: Yes or No

3. Type _____ Date _____ Hospitalized: Yes or No

4. Type _____ Date _____ Hospitalized: Yes or No

Have you ever had x-rays taken? Yes or No If yes, when? _____

What type of clinic? _____ Area(s) of the body_____

Please list the top 3 stresses in each category:

1. Physical stress (falls, accidents, duties at work, repetitive movements, posture etc.)
   a. _____
   b. _____
   c. _____

2. Bio-chemical stress (smoke, junk food, missed meals, lack of water)
   a. _____
   b. _____
   c. _____

3. Psychological stress (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

The Beginning Years

Research is showing that many health challenges that occur later in life originated during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

Birth to 17 years of age	Yes	No	Unsure
Did you have any serious childhood illnesses?	_____	_____	_____
Did you have any serious falls as a child?	_____	_____	_____
Did you play sports?	_____	_____	_____
Did you take/use any drugs? (prescribed or not)	_____	_____	_____
Did you have any surgery?	_____	_____	_____
Were you involved in any car accidents?	_____	_____	_____
Any prolonged use of medicine (i.e.antibiotics)	_____	_____	_____
Were you vaccinated?	_____	_____	_____

Comments: _____

_____

Adult (18 to present)	Yes	No
Do/Did you smoke?	_____	_____
Do/Did you drink alcohol? (more than socially)	_____	_____
Have you been in any accidents?	_____	_____
Have you had any surgery?	_____	_____
Do/Did you play any sports?	_____	_____
Do/Did you participate in extreme sports?	_____	_____

Family Health Profile

At HERING CHIROPRACTIC, we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please list below their names and any health concerns that they may have:

Children: _____

_____

Spouse: _____

Mother: _____

Father:_____

Brothers: _____

Sisters:_____

Other: _____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a late date. I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payer and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16 percent.

The patient understands and agrees to allow this chiropractic office to use their patient health information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your patient health information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. IF there is anyone you do not want to receive your medical records, please inform our office.

Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient Name

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.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)