GENERAL PATIENT INFORMATION

(Please print clearly)

WELCOME

The doctors and staff welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical exam to decide if we can assist you. If we do not believe that your condition will respond to our care, we will not accept you as a patient but will refer you to another health care provider.

Name _____MI_____

Address_____

City_____State_____Zip_____

Phone ( ) _____-_____ Birth Date_____-_____-_____ Gender: Male / Female

Employer _____ Occupation_____

Emergency Contact:_____ Phone: ( )_____

What is your preferred primary method of communication for private health data? (Circle One)

Email Standard Mail Cell Phone Home Phone

I am interested in the following types of care (please circle all that apply):

Pain Relief Nutritional Family Care

Sports Performance/ Injury Preventative/Wellness Services Post-Surgical Care

Other:_____

Who can we thank for referring you to our office?_____

I understand and agree that the doctor has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

I further understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that, unless other arrangements are made with your office, all services are rendered to me are charged directly to me and that I am personally responsible for payment.

Signature_____Date_____-_____-_____

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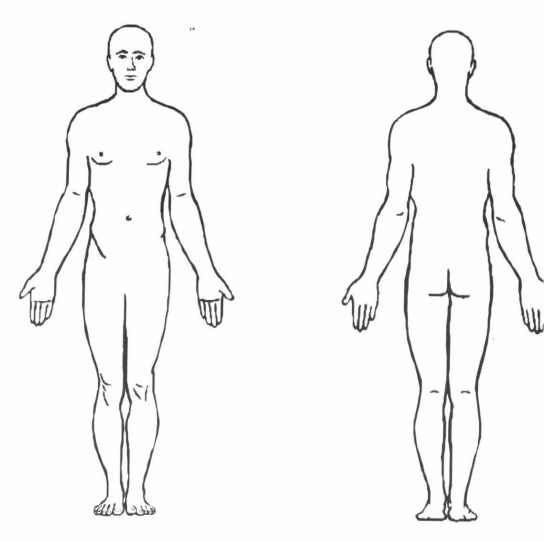
800 Prairie Center Drive Suite 200
Eden Prairie, MN 55344
Office : 952-943-1188

Name:_____ Date:_____

Please list the reason(s) for your visit here, in order of primary importance, and then rank the average level of pain experienced for each complaint (0 is absent pain and 10 is very severe pain) and then describe how often you typically experience pains symptoms.

Symptom	Date first noticed	Average Pain Level (0-10)	How often experienced

Please mark the areas of discomfort or pain on the figures below using the symbol that best described the feeling:



Please put an X in the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	Normal	Somewhat Limited	Severely Limited
Lifting			
Bending			
Standing			
Walking			
Sitting			
Climbing Stairs			
Running			

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Resting in bed			
Intercourse			
Computer Work			
Normal work			
Household Activities			
Recreational Activities			
Other:			

+++Sharp or Stabbing
VVV Dull or aching
OOO Pins and needles
/// Numbness

What do you think caused your problem?_____

What type(s) of therapy have you tried for this condition?

( )Conventional drugs	( )Chiropractic	( )Acupuncture	( )Heat	( ) Activity
( )Diet modification	( )Vitamin/Minerals	( )Herbs	( ) Cold	
( )Homeopathy	( )Other_____		( ) Rest	

Do you have any past history of specific incidental trauma (Motor Vehicle Collisions, Sports Injuries, Significant falls, lifting Injuries, Work Related Injuries)? Yes / No
If yes, please explain with relative dates and type of injury:_____
_____
_____

Name:_____ Date:_____

Do your pain symptoms typically feel worse (please circle): A.M. P.M. Mid-Day Night Constant

Are you currently seeing any other healthcare professional for any other specific condition at this time? Yes or No
Name of Doctor:_____ Clinic & Phone:_____( ) _____

Do you have a history of an overnight hospital stay and/or any surgical history of any kind? Yes or No
1._____ Year_____
2._____ Year_____
3._____ Year_____
4._____Year_____

People usually sleep in more than one position, but in general, are you primarily(circle one): Back, Side Posture, or Facedown sleeper.

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Has this sleeping habit been modified as a result of any current pain complaints you are currently experiencing or has it been changed for any other reason? Yes / No
If Yes, please explain:_____

_____

If you're in any one position for an extended period of time, does the pain get worse? Yes / No
If yes, please explain:_____

_____

Do you sleep well? Yes / No

Do you exercise in a reasonably consistent fashion? Yes or No
Please circle Primary Activities:

Exercise Class	Yoga	Stretching	Other:_____
Free Weight Lifting	Swimming	Treadmill	
Walking	Cycling	Elliptical	
Running	Resistance Machines	Martial Arts	

How many times do you exercise per week? _____ Average Time per session? _____

How do you currently rank your overall health right now (circle one)?
Excellent Very Good Good Fair Poor

FOR WOMEN ONLY

Are you pregnant? ( ) Y ( ) N
Number of children_____

If pregnant, how many weeks? _____
How many pregnancies have you had? _____

Please complete the box for all illnesses you have or have had.(1=have had; 2=currently have)

( ) Atrial Fibrillation	( ) Colon Polyps	( ) Cancer: Colon	( )Other_____
( ) Angina Pectoris	( ) Irritable Bowel	( ) Cancer: Esophagus	
( ) Artifical Heart Valve	( ) Ulcers	( ) Cancer: Stomach	
( ) High Blood Pressure	( ) Crohn's Disease	( ) Cancer: Pancreas	
( ) Pacemaker	( ) Ulcerative Colitis	( ) Cancer: Prostate	
( ) High Cholesterol	( ) Liver Cirrhosis	( ) Cancer: Breast	
( ) Heart Attack	( ) Hepatitis	( ) Excessive Alcohol Use	
( ) Bleeding Disorder	( ) Gallstones	( ) Drug Abuse	
( ) Emphysema	( ) Lactose Intolerance	( ) Depression	
( ) Asthma	( ) Pancreatitis	( ) Anxiety	
( ) Tuberculosis	( ) Diverticulosis	( ) Suicide Attempt	
( ) HIV/AIDS	( ) Sprue	( ) Stroke	
( ) Diabetes	( ) Esophagitis	( ) Migraine Headache	
( ) Osteoporosis	( ) Anemia	( ) Endometriosis	

( ) Thyroid Disorder ( ) Latex Allergy ( ) Arthritis

Check those items for which you have had immunizations?

( ) Polio
( ) DPT (diphtheria/pertussis/tetanus)
( ) Measles
( ) Mumps
( ) tetanus booster (last 10 yr)
( ) Hepatitis B
( ) HPV (human papillo virus)
( ) Small Pox
( )Other_____

Please circle and list any family members who have had any of the following problems.

Disease	Relation To You	Disease	Relation To You
Cancer: Colon		Colon Polyps	
Cancer: Breast		Colitis	
Cancer: Prostate		Bleeding Problems	
Cancer: Other		Alcohol Abuse	
Obesity		Hepatitis	
Diabetes		Osteoporosis	
Hypertension		Liver Disease	
Heart Disease		Arthritis	
High Cholesterol		Kidney Disease	
Autoimmune		Mental Illness	
Seizure Disorder		Other:	

Date of last colonoscopy (if over age 50)	Year:	Never – Don't know
Date of last mammogram (if female)	Year:	Never – Don't know
Date of last bone density test (for osteoporosis)	Year:	Never – Don't know

Name:_____ Date:_____

Review Of Systems

Symptoms		Physician Comment

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Lack of energy	Yes No	Constitutional
Trouble sleeping	Yes No	
Weight loss (10 lbs. in I yr.)	Yes No	
Weight gain (10 lbs. in 1 yr.)	Yes No	
Fevers	Yes No	
Hard or infrequent bowel movements	Yes No	GI
Loose or frequent bowel movements	Yes No	
Blood in bowel movements	Yes No	
Vomit blood	Yes No	
Heartburn/indigestion	Yes No	
Food sticks when swallowing	Yes No	
Painful swallowing	Yes No	
Liver/Gall Bladder Disorder	Yes No	
Yellow jaundice	Yes No	
Chest pain	Yes No	Cardiovascular
Irregular heartbeat	Yes No	
Palpitations	Yes No	
Swollen legs	Yes No	
Fainting	Yes No	
Shortness of breath	Yes No	Respiratory
Wheezing	Yes NO	
Coughing up blood	Yes No	
Asthma	Yes No	
Frequent urination	Yes No	GU
Blood in urine	Yes No	
Difficulty urinating	Yes No	
Kidney Disorders	Yes No	
Kidney Stones	Yes No	
Bladder Infections	Yes No	
Loss of bladder control	Yes No	
Prostate Problems	Yes No	
Painful menses	Yes No	
Joint swelling	Yes No	Musculoskeletal
Abdominal Pain	Yes No	
Joint redness	Yes No	
Gout	Yes No	
Muscle aches	Yes No	
Jaw Pain	Yes No	
Unusual or new rash	Yes No	Breast/skin
Paralysis	Yes No	Neuro
Seizures	Yes No	
Loss of memory	Yes No	
Suicide attempts	Yes No	
Excessive Thirst	Yes No	Endocrine
Easy bruising	Yes No	Heine
Allergy to X-ray dye	Yes No	Allergy

Name:_____ Date:_____

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Physiotherapy Safety Checklist

Please Check these items listed if any are known to be true:

	Yes	No
Do you have acute/sub-acute thrombophelebits?		
Do you ever experience any disturbances in cardiac rhythm?		
Do you have any tendency to hemorrhage following acute trauma or do you bleed easily?		
Do you have any electrical implants, such as a pacemaker?		
Do you have any previously diagnosed sensory nerve damage?		
So you have any previously diagnosed blood related conditions, or are you taking any medications with blood thinning propertiers?		
So you have any eye injuries or conditions such as, but not necessarily limited to: glaucoma, retinal detachment or ocular nerve injury?		

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Patient Signature: _____ Date:_____

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Patient Health Information

Patient Name:_____ DOB:_____ Date:_____

Drug Use:

Do you smoke cigarettes? ( )Y ( )N _____packs/day/week How many years____
Do you smoke cigars? ( )Y ( )N _____cigars/day/month How many years____
Do you use illegal drugs? ( )Y ( )N amount/type_____
Do you drink alcohol? ( )Y ( )N _____drinks/day/week/month/year
Do you drink caffeine? ( )Y ( )N _____cups/day/week/month/year
How many cups of water do you drink each day?_____

Do you have any known allergies to any specific medications? Yes or NO
If Yes please list the specific medications and typical reactions:

Medications	Reactions

What is your Preferred language (Circle one)?

English German Portuguese Vietnamese Other:_____
Spanish Italian Chinese Korean
Indian French Japanese Russian

Please complete this section concerning personal demographics: Race (circle one)

Caucasian Asian Native Alaskan More than 1 Race
Black /African American Native American Native Hawaiian/Pacific Islander Other:_____

Thank you for your patience in accurately completing this information! This not only helps us meet required regulations, but it helps us to capture detailed information so that we can be in the best position to provide you with exceptional healthcare and it allows us to be able to communicate in a comprehensive fashion with other healthcare providers when this need arises!

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Current Patient Medication Summary

Patient Name:____ Date:___________________

1) Generic Name of Medication:_______________________________
2) Brand Name of Medication: ________________________________
3) Strength (mg) per dose:____
4) Dosage (how much is take at a time)_________________________
5) Frequency (How many times/day) ___________________________
6) How taken : Oral, Rectal, Sublingual, Injectable, Other:__________
7) Date Prescription was initiated:____________________________________
8) Primary Reason for use:____

1) Generic Name of Medication:_______________________________
2) Brand Name of Medication: ________________________________
3) Strength (mg) per dose:____
4) Dosage (how much is take at a time)_________________________
5) Frequency (How many times/day) ___________________________
6) How taken : Oral, Rectal, Sublingual, Injectable, Other:__________
7) Date Prescription was initiated:____________________________________
8) Primary Reason for use:____

1) Generic Name of Medication:_______________________________
2) Brand Name of Medication: ________________________________
3) Strength (mg) per dose:____
4) Dosage (how much is take at a time)_________________________
5) Frequency (How many times/day) ___________________________
6) How taken : Oral, Rectal, Sublingual, Injectable, Other:__________
7) Date Prescription was initiated:____________________________________
8) Primary Reason for use:____

1) Generic Name of Medication:_______________________________
2) Brand Name of Medication: ________________________________
3) Strength (mg) per dose:____
4) Dosage (how much is take at a time)_________________________
5) Frequency (How many times/day) ___________________________
6) How taken : Oral, Rectal, Sublingual, Injectable, Other:__________
7) Date Prescription was initiated:____________________________________
8) Primary Reason for use:____

Email Permission Form

Our team at SouthWest Chiropractic, LLC, are excited to provide our patients with health-related information, so we can help you make good choices for life-time health! For example, all of our patients are provided with a “Tuesday Minute”, a professionally designed 1 minute video, designed to provide you with excellent updates on nutritional lifestyle. Patients also receive other health-related updates that are well researched and all of these services are provided at no charge and with no obligation.

To receive these health-related services please provide your email address below:

Email:_____

Patient Name:_____

Date:_____

I, the above-captioned individual, give permission for SouthWest Chiropractic to send me periodic health-related updates through my email address. I reserve the right to stop any email communications by notifying SouthWest Chiropractic, by telephone and/or in writing.

Signature:_____

If you do not wish to receive these health related updates please sign below.

Signature:_____ Date:_____

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Health Information Privacy

We may use and disclose your PHI (private health information) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers compensation and similar programs.

We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.
Rights you have:

You have the right to request restrictions on some of the uses of disclosures described above. Except as stated, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information. (A fee for the costs of copying, mailing, labor and supplies associated with your request will be charged.)

You have the right to request amendments to you medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.
This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised privacy policy, which will be made available to patients upon request.

Please sign and date below, acknowledging that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

Signature of Patient or Legal Guardian: _____ Date:_____

Print Name of Patient or Legal Guardian:_____ Date:_____

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SWC

SouthWest Chiropractic, LLC

Chiropractic Informed Consent to Treat

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic imaging and/or other tests on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office personal the nature and purpose of chiropractic adjustments and procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

(Or Patient Representative) (Indicate relationship of signing for Patient)

Patient Signature X_____ Date:_____

Guardian Signature X_____ Date:_____

Doctor Signature X_____ Date:_____

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