New Patient Entrance Application

Welcome! We are honored you chose us to evaluate your condition.
So we may file your insurance forms for you, would you please fill out the personal information below?
If you need assistance please inform the person at the front desk. Thank You!

Personal Information:

Patient Name: _____ Date: _____ Date of Birth: _____ Age: _____ Sex: M F Marital Status: Single Married Divorced Address: _____ City: _____ State: _____ Zip: _____ Home Phone _____ Work Phone _____ Cell Phone _____ E-Mail _____ Employer Name _____ Occupation _____ Emergency Contact _____ Relationship _____ Phone # _____

Insurance Information: *Please present your insurance card to the front desk.*

Primary Insurance Carrier:_____ Name of insured: _____ Primary Insurance ID #: _____ Primary Group ID:_____ Secondary Insurance Carrier:_____ Secondary ID #:_____ Secondary Group ID:_____

Guardian/Spouse/Family Information:

Name: _____ Relationship: _____

Employer Name: _____ Occupation: _____ Home Phone: _____ Work Phone _____ Cell Phone _____ **Children:**

Name: _____ Age: _____ Sex: M F Name: _____ Age: _____ Sex: M F Name: _____ Age: _____ Sex: M F Name: _____ Age: _____ Sex: M F Name: _____ Age: _____ Sex: M F Name: _____ Age: _____ Sex: M F

Referral Information:

How did you find out about us? _____
Who can we thank for your referral? _____

Patient Informed Consent:

I _____, the undersigned patient, consent to the treatments(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment (s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature:_____ Date: _____

Chiropractic Patient History

Location:

What is your primary complaint?_____

_____

_ What caused the onset?_____

When did it start?_____ Does the complaint radiate or travel? If so, where?_____

Timing and Duration: *(please circle all that apply)*

Since the onset of your complaint how has it been changing? **Getting better No change Getting worse** How often do you experience this complaint? **Constantly Frequently Occasionally Intermittently** Does your complaint worsen? If so, when? **Morning Midday Night Sleep Work Other:** How much as the complaint interfered with your normal work? *(Including both work outside the home and housework.)* **Not at all A little bit Moderately Quite a bit Extremely**

Severity:

Use the key below to rate the severity of your pain.

0 = No pain 1= Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate 6 = Moderate to Severe 7 = Mildly Severe 8 = Severe 9 = Very Severe 10 = Excruciation

Please **circle** where you rate your pain: 1 2 3 4 5 6 7 8 9 10

Quality:

How would you describe the sensation of your complaint? *(please circle all that apply)*

Sharp Pain Shooting Numbness Tingling Tightness/Stiffness

Dull Ache Burning Throbbing Stabbing Other:_____

Modifying Factors:

What makes your complaint feel worse? *(please circle all that apply)*

Coughing/Sneezing Standing Lifting Exercising Bending Twisting

Pushing/Pulling Sitting Walking Driving Climbing Other:_____

Alleviating Factors:

What makes your complaint feel better? *(please circle all that apply)*

Rest/Sleep Stretching Lifting Exercising Bending Twisting

Pain Medication Ice Heat Shower Walking Other:_____

Previous Treatment:

Who have you seen for this condition? *(please circle)* Medical Doctor Physical Therapist Chiropractor Other: Have you had Chiropractic care in the past? If so, when? Yes No _____/_____/_____

Risk Factors:

Do you have a pacemaker? Yes No Are you pregnant? Yes No Do you have any metal implants or devices? Yes No

History was obtained from: Patient Parent Guardian Child Other:_____

Past and General History

To help us better understand your unique condition please complete the information below related to your past and general history.

Past History: Whether present and/or past, please mark below with an 'X.'

Present Past Condition Present Past Condition Present Past Condition Present Past Allergies Angina/Chest Pain Heart Problem(s) Seizures Animal Dander Arthritis HIV Sleeping Problems Dairy Products Asthma Irritability Soreness Food Allergies Back Pain Joint Stiffness Speaking Problems Grasses Balance Problems Joint Swelling Spinal Curvature Hay Latex Broken Bones Joint Tenderness Stiffness Penicillin Cancer Loss of Sleep Stroke/TIA Perfumes Chills Lumps Tingling Pollen Concentration Loss Masses Thyroid Problems Smoke Diabetes Memory Loss Tremors Sulfa Drugs Dizziness Muscle Cramps Vertigo Others Please List: Fainting Muscle Pain Weakness Fatigue Nervousness Others Please List:
Fever Night Sweats
Gout Numbness
Headaches Paralysis

Medication and Surgical History: Please mark below with an 'X.'

Surgery	Yes	No	Year	Surgery	Yes	No	Year	Have You Ever Taken	Yes	No	Year
Appendix				***Women***				Anti-Depressants			
Colon				Breast				Birth Control			
Gall Bladder				Uterus				Blood Pressure Medication			
Heart				Ovary				Cholesterol Medication			
Hernia								Cortisone			
Kidney				***Men***				Insulin			
Stomach				Prostate				Male/Female Hormones			
Tonsils								Thyroid Medication			
								Tranquilizers/Sedatives			

What other supplements, vitamins or medications are you taking? _____

_____

_____

What, if any, major injuries have you had, and when? _____

_____

Have you been hospitalized? If so, when and why?_____

_____

Social and Family History

Social History: *(please circle)*

What is the highest level of schooling you have completed?

Still in school Some high school High school Some college College Graduate School

What is your current work status?

Employed full time Employed part time Retired Unemployed Disabled Student

How often do you exercise?

Never 1-3 times/month 1-2 times/week 3-4 times/week Daily

How would you rate the intensity of your exercise?

Never exercise Low level Moderate level High level Competition level

How many hours do you sleep per night?

<4 hours 5-6 hours 7-8 hours 8-10 hours >10 hours

How often do you eat a balanced diet?

Never Rarely Sometimes Regularly Always

How often do you drink caffeinated beverages?

Never 1-3 times/month 1-2 times/week 3-4 times/week Daily >2/day

How often do you smoke cigarettes?

Never Past 1-3 packs/month 1-2 packs/week 3-4 packs/week >1 pack/day

How often do you drink alcohol?

Never Past 1-3 drinks/month 1-2 drinks/week 3-4 drinks/week Daily

Have you used street drugs in the past six months? Yes No

Daily Activities:

So that we may have an idea as to your daily routine, please list a few of your daily activities and your favorite hobbies.

_____

_

_____

Does your current condition affect your performance in these activities or hobbies? Yes No If so, how? _____

_____

Family History Information:

Please indicate if anyone in your family currently has, or has in the past, suffered from any of the conditions listed below:

Arthritis Whom: _____ High Blood Pressure Whom: _____ Back Pain Whom: _____ High

Cholesterol Whom: _____ Cancer Whom: _____ Osteoporosis Whom: _____ Diabetes

Whom: _____ Stroke Whom: _____ Heart Disease Whom: _____ Thyroid Conditions

Whom: _____

Patient/Guardian Signature:_____ Date: _____ Dr:_____

What to expect after your first adjustment:

Please read the following information carefully. Sign the bottom of this sheet to indicate that you un derstand the instructions and information given.

If you have never been adjusted, or if it has been awhile since your last adjustment, you may experi ence soreness or discomfort for a few hours to a few days. This is a normal reaction to chiro practic adjustments.

If you are sore, use ice packs on the affected area. Ice therapy consists of the use of ice packs at 20 minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.

Do not use heat except under the doctor's instruction. Heat may aggravate your injury. Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting, weights, impact aerobics, racquetball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as raking, digging, lifting heavy objects such as groceries, pets and children, and any other activities that could aggravate or re-injure your condition.

Unless indicated by the doctor, you may return to work/school after your appointment. If a sudden movement causes sharp or severe pain or if you experience swelling, contact the clinic at 763.444.4668

I have read and understand the instructions given for my follow-up care.

(Patient's Signature)

I understand and agree that Health and Accident insurance policies are in arrangement between an Insurance Carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the Insurance Company and any amount to be paid directly to this office will be credited to my account upon receipt. I permit this office to submit my signed authorization along with the Insurance Form, therefore, direct payment of insurance proceeds to be paid to Nature's Way Chiropractic/Dr. Sarah Ruther. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for pay ment. I also understand that if I suspend or terminate my care and treatment, any fee for professional services to me will be immediately due and payable. I also authorize Nature's Way Chiropractic Clinic to release my health records and reports to my family physician.

Patients Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____