FILE #:
ID CHECK:

CHIROPRACTIC NEW PATIENT PAPERWORK

Patient Information Date:_____/_____/_____

Name:_____

Address:_____

_____

City State ZIP

Date of Birth:_____/_____/_____ Age:_____

Gender: _____

Contact Information

Cell Phone #:_____

Secondary phone#:_____

Email:_____

In Case of Emergency, Contact

Name:_____

Relationship:_____

Primary Phone #:_____

Other Information

Occupation:_____

Employer:_____

Marital Status O Single O Married O Divorced

Spouse's Name:_____

Have you ever been to a chiropractor before?

O Yes O No

How did you hear about our clinic?_____

_____

Insurance Policy Information:

Policy Holder:_____ Relationship:_____

Birth Date:_____/_____/_____ Gender:_____

Employer:_____

Primary Phone #:_____

Insurance Company:_____

I.D. #_____

Group/Policy #:_____

_____

Signature of Patient or Responsible Party

Condition History:

When did your condition first appear? _____

Is your current situation the result of an injury? O Yes O No

If so, what was the nature of your accident?

O Auto O At work O Home O Other

To whom have you made a report of your accident?

O Auto insurance O Employer O Work Comp O Other

Have you seen anyone else regarding this problem? O Yes O No

If yes, who?_____

Phone #:_____

Have you ever been disabled? O Yes O No

If yes, when and how? _____

_____

_____

Condition Information:

Reason for Visit:_____

Is your current condition getting any worse? O No O Yes O Unknown

Thinking of the last 2 weeks, please list your main concerns in descending order in the box below, the first being your highest concern.

Please mark the intensity of your pain using a 1-10 scale.
1 = no pain, and 10= the most intense pain you've felt

Example: _____*Neck*_____

1 2 (3) 4 5 6 7 8 9 10

Area #1:_____

1 2 3 4 5 6 7 8 9 10

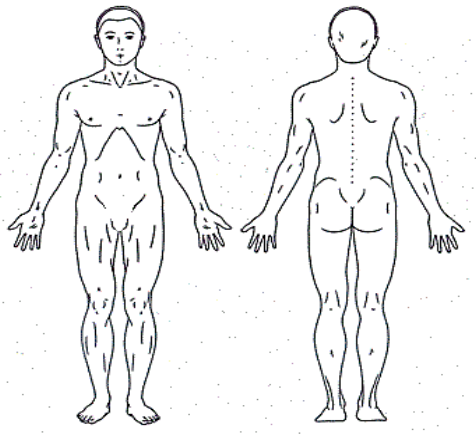
Area #2:_____

1 2 3 4 5 6 7 8 9 10

Area #3:_____

1 2 3 4 5 6 7 8 9 10

Indicate on diagram below where your pain is located.



What is your… Height _____? Weight _____?

Exercise level: O None O Minimal O Moderate O Strenuous ____times/week Type:_____

Regular habits: O Smoking (____ packs/week) O Alcohol (____ drinks/week) O Caffeine (____ cups/day)

Please circle "past" or "now" for each item below that applies to your health. You may leave blank if not applicable.

General	Digestion	Eyes/Ears/Nose/Throat	Respiratory
Past Now Medical Allergy If so, what?	Past Now Belching/Gas	Past Now Asthma	Past Now Chest Pain/ Tightness
Past Now Chills	Past Now Colon Trouble	Past Now Tonsillitis	Past Now Chronic Cough
Past Now Convulsions	Past Now Constipation	Past Now Sinusitis	Past Now Difficulty Breathing
Past Now Dizziness	Past Now Diarrhea	Past Now Allergies	Past Now Wheezing
Past Now Fainting	Past Now Excessive Hunger	Past Now Earache	Past Now Spitting Blood
Past Now Fatigue	Past Now Gallbladder Trouble	Past Now Ear Discharge	Past Now Phlegm Production
Past Now Fever	Past Now Hemorrhoids	Past Now Ear Noise	Past Now Bronchitis
Past Now Loss of Sleep	Past Now Jaundice	Past Now Frequent Colds	**Genitourinary**
Past Now Loss of Weight	Past Now Liver Trouble	Past Now Hay Fever	Past Now Bed Wetting
Past Now Nervousness	Past Now Nausea	Past Now Hoarseness	Past Now Blood in Urine
Past Now Nerve Pain	Past Now Pain in Stomach	Past Now Nasal Congestion	Past Now Frequent Urination
Past Now Night Sweats	Past Now Poor Appetite	Past Now Nose Bleeding	Past Now Urinary Incontinence
Past Now Numbness (arms, legs or hands)	Past Now Vomiting	Past Now Pain in Eyes	Past Now Kidney Infection
Past Now Unconsciousness	Past Now Vomiting Blood	Past Now Migraines	Past Now Painful Urination
Muscles/Joints	**Cardiovascular**	Past Now Poor Vision	Past Now Prostate Trouble
Past Now Backache	Past Now High Blood Pressure	Past Now Crossed Vision	**For Women Only**
Past Now Pain Between Shoulder Blades	Past Now Low Blood Pressure	Past Now Poor Hearing	Past Now Cramps/Backache
Past Now Stiff Neck	Past Now Pain Over Heart	**Skin**	Past Now Excessive Flow
Past Now Swollen Joints	Past Now Poor Circulation	Past Now Bruise Easily	Past Now Hot Flashes
Past Now Foot Trouble	Past Now Heart Trouble	Past Now Dryness	Past Now Irregular Cycle
Past Now Painful Tailbone	Past Now Rapid Heart Rate	Past Now Eczema	Past Now Miscarriage
Past Now Spinal Curvature	Past Now Slow Heart Rate	Past Now Psoriasis	Past Now Painful Periods
Past Now Tremors	Past Now Stroke	Past Now Hives	Past Now Vaginal Discharge
Past Now Twitching	Past Now Swollen Ankles	Past Now Itching	Past Now Birth Control If so, what?
Past Now Weakness	Past Now Varicose Veins	Past Now Sensitive Skin	Past Now IUD
Past Now Arthritis	Past Now Anemia	Past Now Skin Eruptions	Past Now Last Pap Exam?_____
Past Now Jaw Pain	Past Now Arrhythmia	Past Now Boils	Past Now Hormone Replacement

Have you had any of the following diseases? (Circle all that apply.)

Diabetes Cancer Hepatitis Tuberculosis Pneumonia Venereal Disease Alcoholism

Lupus Measles Goiter Epilepsy Polio Rheumatic Fever Chicken Pox

Pleurisy Mental Disorder Rheumatoid Arthritis Whooping Cough Other:_____

Operations and Procedures:

Date		Date		Date		Date	
_____	Tonsillectomy	_____	Gall Bladder	_____	Back Surgery	_____	Hernia
_____	Vaccinations	_____	Tubes in Ears	_____	Female Organs	_____	Thyroid
_____	Appendectomy	_____	Stomach	_____	Cesarean	_____	Other

Family History:

O Diabetes O Heart Problems O Kidney O Cancer O Autoimmune Disorder O Other:_____

_____ _____ _____ _____ _____ _____

Are you currently taking any medications or nutritional supplements/herbs?_____

_____

Please read each section thoroughly, INITIAL EACH SECTION and SIGN at the bottom. Thank you!

X_____ I have had the option to received and I understand how my Protected Health Information (PHI) will be used in this office and I agree to these policies and procedures. If I have questions or concerns about how my PHI is/will be used I understand that I may contact the Compliance Officer at the back of the Notice of Privacy Practices at any time.

Authorization to Release Information

X_____ I authorize Lauderdale Wellness Center to release all information related to the care I received to my HMO, Insurance Company, third party payer or their designee, or other members of my healthcare team. This may be done by mail, email, telephone or fax. I understand that this may be necessary for the payment of my bill, determining benefits or for utilization and quality review purposes. I understand that Lauderdale Wellness Center may send an informational newsletter via email to the email address I provide. I may cancel the newsletter at any time by contacting the Privacy Officer.

Assignment of Benefits

X_____ I assign all benefits payable to me for my care at Lauderdale Wellness Center. I understand that this health care facility will be paid directly by the insurance company or other payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as this original.

Guarantee of Payment

X_____ I understand and agree that health and accident insurance policies are an agreement between an insurance company and myself. Furthermore, I understand that Lauderdale Wellness Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid to Lauderdale Wellness Center will be credited to my account on receipt. I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of Lauderdale Wellness Center. If I fail to do so, I agree that I am liable to Lauderdale Wellness Center for the interest (at a rate of 18% per annum on the balance due more than 30 days), court costs, reasonable attorney fees, and any other necessary costs to enforce payment on any part of said account(s).

Consent for Treatment

X_____ You have the right as a patient to be informed about your condition and the recommended treatment to be used so that you may make an informed decision about whether or not to undergo the procedure after knowing the risks and benefits involved. This disclosure is simply meant to give you all the information, even if the risk is very remote, so that you may give or withhold your consent for treatment.

Doctors of Chiropractic, Medical Doctors and Physical Therapists using manual therapy treatment for patients with headaches and cervical spines complaints are required to explain that there have been rare cases of injury to the vertebral artery as a result of treatment. Such an injury has been known to cause stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately from 1 per 400,000 to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please feel free to speak to your practitioner.

As with any health care procedure, complications may arise during or after treatment. These complications may include soreness, muscle or ligament sprain, dislocations, fractures, disk injury, or physiotherapy burn. These are extremely rare occurrences.

Authorization to Treat a Minor (under the age of 18)

X_____ I hereby request and authorize Dr. Brian Malzer or his associates to perform diagnostic tests and render chiropractic adjustment and other treatments to my minor son/daughter. This authorization is intended to include radiographic examination at the doctor's discretion. As of this date I have legal right to select and authorize health care services for the minor child. Under the terms and conditions of my divorce (if applicable) separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authorization to select and authorize this care should be revoked or modified in any way, I will immediately notify Lauderdale Wellness Center.

X_____ _____ _____

Signature (of patient or responsible party) **Date** **Relationship to Patient**

LAUDERDALE WELNESS CENTER
2443 LARPENTEUR AVE W
LAUDERDALE MN 55113
(651)917-9800

Consent to use PHI

Acknowledgment for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information (PHI)

Your PHI will be used by Lauderdale Wellness Center or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from your or created by this office.

➡ **X_____ I am aware that at any point I may request a copy of the Notice of Patient Privacy Policy**

Requesting a Restriction on the Use or Disclosure of Your PHI

- You may request a restriction on the use or disclosure of your PHI
- This office may or may not agree to restrict the use or disclosure of your PHI
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of your PHI in violation of an agreed upon restriction will be a violation of the federal privacy standards

Notice of Treatment in Open or Common Areas.

We do not offer treatment in common areas

Revocation of Consent

You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

➡

_____ _____

Patient or Legally Authorized Individual Signature | Date

_____ _____

Print Patient's Full Name | Time

_____ _____

Witness Signature | Date