Barnesville Chiropractic

423 Front Street North
Barnesville, MN 56514
218-354-2148

Date _____

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Birth Date _____ Sex: ☐Male ☐Female

Email Address _____ Cell Phone _____

Home Phone _____ Work Phone _____

Occupation _____ Employer _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Number of Children _____

Emergency Contact Name _____ Phone _____

Address _____ City _____ State ___ Relationship _____

==========

What is your major complaint(s)? _____

_____

When did the symptom(s) begin? _____

Injury/Pain from Recent Trauma? ☐ Auto Accident ☐ Sports Injury ☐ Work Injury
☐ Other _____

Have you experienced the symptom(s) before? _____ If yes, when? _____

What makes your symptoms worse? _____

_____

What makes your symptoms better? _____

_____

BARNESVILLE CHIROPRACTIC

CASH PAYMENT POLICY

Patient's Name: _____
(PRINT NAME PLEASE)

All patients please note: **The responsibility of payment rests directly with the patient.**

Cash patients must pay in full at the time of service. Barnesville Chiropractic accepts cash, check, and VISA/MASTERCARD/DISCOVER/DEBIT. Patients paying by check with insufficient funds will be charged an additional $25 along with original cost of treatment rendered.

PERSONAL INJURY (Automobile accidents and non-personal injury): Patient is responsible to inform Jewett Lake Enterprises of any/all personal injuries with open claims through an auto insurance company.

I HAVE READ AND UNDERSTAND THE BARNESVILLE CHIROPRACTIC CASH PAYMENT POLICY AND AGREE TO THE ABOVE TERMS.

Patient's Signature: _____ Date: _____

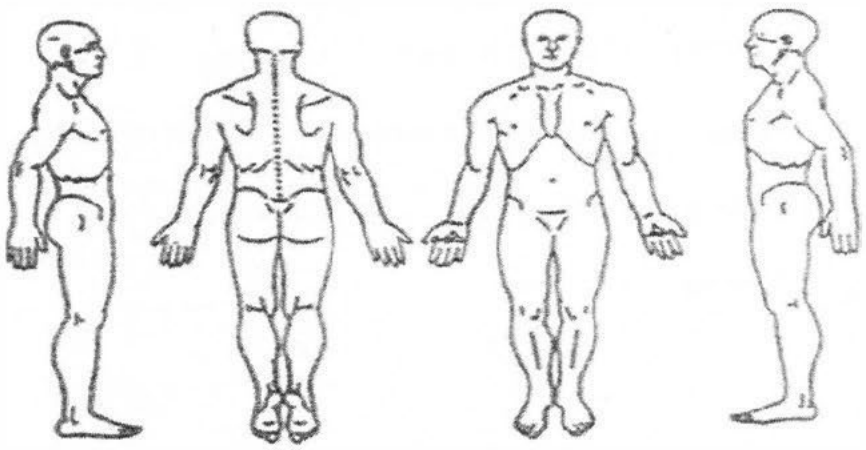
LIABILITY WAIVER

I understand and waive my ability to pursue any legal action for chiropractic treatment rendered through

BARNESVILLE CHIROPRACTIC being administered at 423 Front Street North Barnesville, MN 56514

Patient's Signature: _____ Date: _____

Please circle the area(s) where you are experiencing pain.



Right Side View L Back R R Front L Left Side View

Pain Index: • Achy • Burning • Dull • Nagging • Numbness • Sharp • Stabbing • Spasm • Tingling
Other_____

Pain Scale: On a Scale from 0 - 10. (1 least pain - 10 worse)

1 – Minimal
2 – Very Mild
3 – Mild
4 - Mild to moderate
5- Moderate
6 – Moderate to Severe
7 – Moderately Severe (Restricts some activity)
8 – Severe (Limits most activity)
9 – Very Severe
10 – Excruciating

What is your pain intensity right now? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the most intense pain has been? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the least intense the pain has been? (circle) 0 1 2 3 4 5 6 7 8 9 10

Does it cause pain to cough or sneeze? • Yes or • No

Does this condition interfere with your sleep? • Yes or • No

Have you seen any other doctors or providers in regard to the symptom (s)? • Yes or • No

When? _____ Name of Doctor/ Clinic _____

Date Consulted: _____ Diagnosis: _____

Treatments Received: _____

Have you been treated by a Chiropractor? • Yes or • No **Name:** _____

Circle those activities below during which you experience difficulty or pain.

• Sleeping	• Driving	• Standing	• Bending forward	• Working
• Lying on your back	• Pulling	• Sitting	• Bending Backward	• Working at computer
• Lying on your side	• Pushing	• Walking	• Lifting	• Working Out
• Lying on your stomach	• Reaching	• Running	• Carrying	• Other _____

Headaches

Do you get headaches? • Yes • No Frequency:_____ Family History of headaches? • Yes • No

Abnormal Blood Pressure? • Yes • No • High • Low Nausea, Vomiting or Visual issues? • Yes • No

When was your last eye exam? _____ Pain or cracking in jaw? • Yes • No

Neck Pain

Does the pain radiate into the arm/hand? • Yes • No • Right Arm • Right Hand / • Left Arm • Left Hand

Do you have pain moving your head? • Yes • No, (if yes, which direction) • Right • Left • Up • Down

Low Back Pain

Does the pain radiate into the leg or feet? • Yes • No, • Right leg • Right foot • Left leg • Left foot

Do you have numbness or tingling into leg(s)? • Yes • No, If yes where_____

Do you have impairment of bowel or urinary function? • Yes • No, If yes describe _____

If Female, are you pregnant? • Yes • No, If yes when is your due date?_____

List Medications you are taking: _____

Have you ever had any surgeries or been hospitalized? • Yes • No, If yes please describe.
Type of Hospitalization /Surgery: _____ Date: _____
Type of Hospitalization /Surgery: _____ Date: _____

Have you been x-rayed or received MRI, CAT scan in the past 12-18 months? • Yes • No
If yes, what part of your body?_____Where?_____When?_____

Do you have a family physician or Clinic? • Yes • No, Physician or Clinic Name:_____

Please check all additional complaints that you have at this time.

- Neck Pain/Stiffness
- Neck motion Restricted
- Upper Back Pain/stiffness
- Mid Back Pain/stiffness
- Low Back Pain/stiffness
- Shoulder Pain – Left or Right
- Leg Pain – Left or Right
- Pins & Needles – Ams or Legs
- Jaw Pain – TMJ Pain
- Chest Pain
- Heart Disease
- Diabetes
- HIV (Aids)
- Loss of Smell
- Loss of Taste
- Loss of Concentration
- Loss of Balance
- Sinus Trouble
- Cold Hans/Feet
- Vision Problems
- Hypertension
- Anxiety
- Depression
- Fatigue
- Insomnia
- Shortness of Breath
- Diarrhea
- Constipation
- Nausea
- Vomiting
- Arthritis
- Pain Behind Eyes
- Fainting
- Dizziness
- Please Specify Location
  - Numbness _____
  - Swelling _____
  - Cuts _____
  - Bruising _____

Do you have, or have ever had, any diseases or medical problems not listed? Yes or No
If yes, please list: _____

Have you ever had: _____ Motor Vehicle Injury _____ Sports Injury_____ Work Injury
If Yes, When, please explain _____

Authorization and Assignment

I authorize Barnesville Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges insured by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of proceeds of any settlement of my case, and by any insurer company obligated to make payment to me or you based on whole or in part upon the charges made for your services. I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe.

I undersigned do hereby appoint Barnesville Chiropractic authority necessary to endorse and cash my checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I will be responsible for any costs of collection, attorney fees or court costs required to collect my bill.

Date _____ Patient Signature _____

Informed Consent

I hereby authorize physicians and staff at Barnesville Chiropractic 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 member at Barnesville Chiropractic responsible for any errors or omissions that I may have made at completion of this form.

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

Chiropractic is a system of health care delivery and therefore, as with any health care system, we cannot promise a cure for any symptoms, conditions or disease 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 procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury – Occasionally 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 rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for case considered at risk. Treatment is performed carefully 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 occurs, you should report it to your doctor or staff member.
Stroke – Stroke is the most serious complication of chiropractic treatment. 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. Please understand Barnesville Chiropractic has private rooms for treatments.

If you have any questions concerning this form or above statements, please ask your doctor.
Having carefully read above, I hereby give informed consent to have chiropractic treatment administered.

Date _____ Patient Signature _____

BARNESVILLE CHIROPRACTIC

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operation.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? ☐YES ☐NO

If YES, please name the members allowed:

_____ _____

_____ _____

This consent was signed by: _____

(PRINT NAME PLEASE)

Patient's Signature: _____ Date: _____

Emergency Contact: _____

Emergency Contact's Phone Number: _____