## ABOUT THE PATIENT

Centered Health Chiropractic. 9920 Foley Blvd suite 140
Coon Rapids, MN 55433

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____Gender ❑ M ❑ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

e-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Emergency Contact _____ ph # _____

Name of Medical Doctor(s)_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Centered Health Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

## REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

_____

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

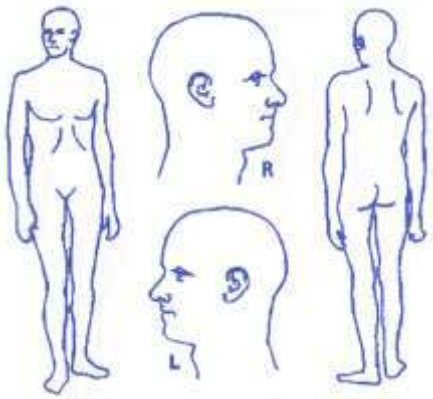
NOTES: _____

_____

_____

Are you pregnant?
❑ Yes ❑ No

Please mark All areas of concern.



# GENERAL HEALTH HISTORY

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Patient Name_____ *Mark the conditions that apply to you.*

| Past | Present | | Past | Present | |
|---|---|---|---|---|---|
| ❑ | ❑ | Headaches | ❑ | ❑ | Urinary Problems |
| ❑ | ❑ | Migraines | ❑ | ❑ | Easy Bruising |
| ❑ | ❑ | Shortness of Breath | ❑ | ❑ | Tobacco Use |
| ❑ | ❑ | Allergies / Asthma | ❑ | ❑ | Dental Problems |
| ❑ | ❑ | Medication Side Effects | ❑ | ❑ | Fibromyalgia |
| ❑ | ❑ | Diabetes | ❑ | ❑ | Blood Thinner use |
| ❑ | ❑ | Hands or Feet cold | ❑ | ❑ | HIV Positive |
| ❑ | ❑ | Muscle aches | ❑ | ❑ | Cancer |
| ❑ | ❑ | Trouble Walking | ❑ | ❑ | Depression |
| ❑ | ❑ | Leg / Foot Numbness | ❑ | ❑ | Alcohol Use |
| ❑ | ❑ | Fainting | ❑ | ❑ | ___High or ___Low Blood Pressure |
| ❑ | ❑ | Gall Bladder Trouble | ❑ | ❑ | Stroke History |
| ❑ | ❑ | Ringing in Ears | ❑ | ❑ | High Cholesterol |
| ❑ | ❑ | Ear Problems | ❑ | ❑ | TMJ |
| ❑ | ❑ | Sleeping Problems | ❑ | ❑ | Digestive Problems |
| ❑ | ❑ | Vision Problems | ❑ | ❑ | Pain all Over |
| ❑ | ❑ | Thyroid Problems | ❑ | ❑ | Tension / Irritability |
| ❑ | ❑ | Liver Disease | ❑ | ❑ | Chest Pains |
| ❑ | ❑ | Kidney Problems | ❑ | ❑ | Heart Pacemaker |
| ❑ | ❑ | Light Bothers Eyes | ❑ | ❑ | Heart Problems |
| ❑ | ❑ | Other _____ | | | |

1. List any medications are you taking:_____
_____
2. Please list all doctors you are currently seeing: _____
_____
3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name_____
_____
_____

# PAST HISTORY

4. List any past auto collisions:_____ Was any care received?_____
5. List any past work injuries: _____ Was any care received?_____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____
_____
8. Please list any past hospitalizations and surgeries: _____
_____

# FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____
Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____
Is there any other family history you want us to know?_____