Great Lakes Chiropractic
116 Central Ave East St. Michael, MN 55376
763-515-6650

ADULT HEALTH HISTORY

Date: __________ Name: ______________________________ Email: ________________________________

Address: __________________________________ City: ____________________State:_____ Zip: _________

Home Phone: ____________________Work Phone: ____________________ Cell Phone: _________________

Occupation: _________________________ Employer/City: ____________________/____________________

Name of Spouse/Guardian: _________________________ Spouse's Occupation________________________

Spouse's Employer/City: ________________/________________ Spouse Work Phone: _________________

Social Security#:______________________ Age: ______ Birth Date: ___________ Marital Status: M S W D

Race/ethnicity________________________ Language Preference_______________________

Number of Children: __________ Names and Ages of Children: _____________________________________

____

Name of Nearest Relative: ________________________________ Phone: _____________________________

How were you referred to our office: ____

Family Medical Doctor: ____

Have you had any previous chiropractic care? Yes or No If yes, when was your last adjustment: ____________

HISTORY OF PRESENT ILLNESS:
Chief Complaint: Purpose of this appointment:
____
Date symptoms appeared or accident happened:
____
Is this due to: Auto____ Work ____ Other ____
Have you ever had the same or a similar condition? Yes or No If yes, when and describe: __________________
____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

___ Low back pain
___ Pain between shoulders
___ Headaches
___ Neck Pain
___ Joint Pain/Stiffness
___ Arm Pain
___ Clicking Jaw
___ Heartburn
___ General Stiffness
___ Fatigue
___ Cold/Tingling Extremities
___ Numbness
___ Fainting
___ Dizziness
___ Loss of Sleep

FEMALES ONLY: When was your last menstrual cycle? ________
Are you pregnant? Yes ___No ___ Not Sure___ Due Date:_______________________

PAST MEDICAL HISTORY:

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

__Broken or Fractured Bones __Osteoarthritis __Eating Disorder __HIV Positive
__Circulatory Problems __Epilepsy __Alcoholism __Gall Bladder
__Rheumatoid Arthritis __Pace Maker __Drug Addiction __Ulcers
__Seizures/Convulsions __Strokes __Coughing Blood
__A Congenital Disease __Cancer __Depression
__Excessive Bleeding __High/Low Blood Pressure

Do you have a history of stroke or hypertension? ____

Have you had any major illnesses, hospitalizations, injuries, falls, auto accidents or **surgeries**? Please include dates: ____
____

Have you been treated for any health condition by a physician in the last year? Yes or No
If yes, describe: ____

MEDICATIONS:

What medications or drugs are you taking?
____
____

List any nutritional supplements you are taking (vitamins, herbs, naturopathic remedies, etc.):____

Do you have allergies of any kind? Yes or No If yes, describe: __________________________________
____

Please list any other health problems you have, no matter how insignificant they may be:
____

FAMILY HISTORY: (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

Tuberculosis _______ Cancer ___________ Mental Illness _______
Diabetes __________ Asthma ___________ Heart Disease _______
Stroke ____________ Kidney Disease _____ Lung Disease ________
Arthritis ___________ Liver Disease _______ Headaches __________
Low back pain ______ Neck Pain __________ Other: ________________________
Migraines __________ Disc Injuries ________

SOCIAL HISTORY:

Do you drink alcoholic beverages? ___ If so, how much per week? ______________________________
Do you smoke/use tabacco? ____ If so, packs per day: ______________________ Have you ever smoked?_____
Do you consume caffeine? ____ If so, how much per day:____
Do you exercise? __________ If yes, what is the frequency and type of exercise? _______________________
What are your hobbies? ____
What percentage of time during the day (at home or at your job away from home) do you spend:
lifting_____ sitting_____ bending______ working at a computer_______

Patient's Signature: ____ Date: ________________

Guardian's Signature Authorizing Care: __________________________________Date: ________________

Great Lakes Chiropractic
116 Central Ave East   St. Michael, MN 55376
763-515-6650

STANDARD CONSENT

When a patient seeks Chiropractic health care, and we accept a patient for such care, it is essential for both doctor and patient to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a Chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for these findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's natural ability toward self-healing. Our only method is specific adjusting to correct vertebral subluxations.

Any procedure intended to help may also do harm. While chiropractic procedures done in this office are usually considered remarkably safe and effective, please understand there are occasional and rare complications which have been documented. While the chances of experiencing these complications are extremely small, it is the practice of this office to fully inform and educate all of our patients about them. Cervical manipulations have rarely caused injuries to the small blood vessels that go to and from the upper neck to the brain. The risk of this occurring is thought to be one in three million to one in fourteen million, according to several studies. These other complications include but are not limited to:

pain	burns	swelling	sensory changes
soft tissue injury	bruising	bleeding	stroke(CVA)
discoloration	fracture	dizziness	inflammation
disc injury	nausea	weakness	soreness

By signing below, I understand that there is no guarantee or warranty of a specific cure or result. I understand that I can request specific additional information from the doctor regarding treatment risk. Given this information, I consent to care.

Patient Signature ____ Date____________________________

Consent to Treat a Minor ____ Date____________________________

Guardian or Spouse's
Signature of Authorizing Care ____________________________________ Date____________________________

Guardian's Social Security Number (required to treat a minor) ____

Great Lakes Chiropractic
116 Central Ave East St. Michael, MN 55376
763-515-6650

FINANCIAL POLICY

INSURANCE: You should be prepared to present your current insurance card. All claims will be submitted to your insurance carrier unless otherwise specified. We do not have a way to access the terms of your insurance policy and therefore cannot quote coverage or benefit levels or guarantee that your insurance company will cover the services we have provided. If you have questions, please call your insurance carrier directly.
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Great Lakes Chiropractic 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 directly to Great Lakes Chiropractic will be credited to my account. However, I agree that I am personally responsible for all services not paid for by my insurance. I also am responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

COPAYS: Co-payments are due *on the day of your appointment.*

MEDICARE: We do accept Medicare. Medicare covers manual manipulation of the spine *only.* All other services are NOT covered. These services include, but are not limited to: x-rays, examinations and therapies. You are required to pay any deductible and remaining balance after Medicare processes your claim.

WORKER'S COMPENSATION/PERSONAL INJURY: Please inform us immediately if you are injured on the job or are involved in an accident. We will work with you to manage your care and submit your fees.

SECONDARY INSURANCE: Please inform us of any secondary insurance you may have.

CASH ONLY: For patients who carry insurance in which we are not in-network or for patients who do not wish to submit claims to their insurance company, we offer a cash-payment office visit. If this is something you may be interested in, please ask at the front desk. This charge will be due at the time of your appointment.

STATEMENTS: After your insurance company has processed your claims, you will receive a statement from us for the unpaid balance. Your payment is due within 30 days of the statement date. If you are unable to pay your balance in full prior to the due date, please call our billing office at 763-777-9313 to set up payment arrangements.

MISSED APPOINTMENT POLICY: Your time is important, as is ours. If you must cancel or reschedule an appointment, please make every effort to do so at least 24 hours prior to your appointment time. ***If you do not call to cancel/reschedule and you do not come in for your appointment, a $20.00 fee will be charged to your account.***

PAYMENT OPTIONS: We accept cash, checks, debit card, and credit card.

I have read and understand the Financial Policy of Great Lakes Chiropractic. I understand that I am responsible for all services not paid for by my insurance including deductibles, copayments, or non-covered services.

____ ____________________

SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY, IF MINOR) **DATE**