Great Lakes Chiropractic of St. Michael
116 Central Ave East St. Michael, MN 55376
PH: 763-515-6650 | FAX: 763-777-9186

PATIENT INFORMATION:

Date _____ Name _____ Age _____ Birth Date_____

Email _____ Social Security #_____ Marital Status: M S W D

Race/ethnicity_____ Language Preference_____

Address _____ City _____State_____ Zip_____

Home Phone _____Work Phone _____ Cell Phone _____

Occupation _____ Employer_____

Name of Spouse/Guardian _____ Spouse/Guardian Phone _____

Spouse's Employer _____ Occupation _____

Names and Ages of Children _____

_____

Emergency Contact _____ Phone _____

Family Medical Doctor/Clinic_____

How were you referred to our office? _____

INSURANCE INFORMATION:

Motor Vehicle Insurance Company: _____

Adjuster's Name: _____

Adjuster's Phone Number: _____

Policy ID: _____

Claim #: _____

ACCIDENT INFORMATION:

1. Date of accident: _____/_____/_____

2. Time of accident: _____AM / PM

3. How many vehicles were involved in the accident? _____

4. What was the estimated damage to the vehicle you were in? _____

5. What state did the accident occur in? _____

6. What city did the accident occur in? _____

7. What street or intersection were you on when the accident occurred?

_____

8. What direction were you traveling in? Circle one.
North South East West

9. What type of impact was the auto accident? (Ex: rear ended / head on)

_____

10. Did your vehicle hit anything after the accident? If yes, please describe:

_____

11. Where were you sitting in the vehicle? Circle one.
Driving / Front passenger / Back seat on driver side / Back seat on passenger side

12. Did you know the accident was coming? Yes ___ No ___

13. What type of vehicle were you in? (Make/Model) _____

14. What type of vehicle impacted yours? (Make/Model) _____

15. At the time of the impact, how fast was your vehicle moving? _____

16. At the time of impact, how fast was the other vehicle moving? _____

17. During and after the crash what happened to your vehicle? (Check all that apply)

___ kept going straight
___ kept going straight hitting a car in front
___ was hit by another vehicle
___ spun around and hit a stationary object
___ hit a stationary object
___ spun around

___ other: Details_____

18. Did you lose consciousness during the accident? Yes ___ No ___

19. How was your head positioned during the accident? _____

20. How was your torso positioned during the accident? _____

21. How were your hands positioned during the accident? _____

22. Did your head hit anything during the accident? No ___ Yes, please describe: _____

_____

23. Did your face hit anything during the accident? No ___ Yes, please describe_____

_____

24. Did your shoulders hit anything during the accident? No ___ Yes, please describe_____

_____

25. Did your neck hit anything during the accident? No ___ Yes, please describe: _____

_____

26. Did your chest hit anything during the accident? No ___ Yes, please describe: _____

_____

27. Did your hips hit anything during the accident? No ___ Yes, please describe: _____

_____

28. Did your knees hit anything during the accident? No ___ Yes, please describe: _____

_____

29. Did your feet hit anything during the accident? No ___ Yes, please describe: _____

_____

30. What kind of headrest was in your vehicle? (circle one)
movable fixed headrest fixed non-movable headrest no headrest

31. Did you have your seatbelt on during the accident? Yes ___ No ___

32. Did you slide out of your seatbelt during the accident? Yes ___No ___

33. What was damaged in your vehicle? (Check all that apply)

___ windshield	___ rear bumper	___ mirror
___ steering wheel	___ front bumper	___ knee bolster
___ dashboard	___ trunk	___ back right door
___ rear window	___ front left door	___ back left door
___ side window	___ front right door	___ seat frame
___ entire vehicle totaled	___ other: _____	

34. Choose the items that dented inward:

___ floorboards ___ side door ___ dashboard ___ none

35. Choose the doors that would not open because of the accident:

___ front left ___ front right ___ rear left ___rear right

36. Did you go to the hospital? Yes ___ No ___

37. How did you get to the hospital? _____

38. What was the name of the hospital? _____

39. Were you hospitalized overnight? _____

40. What you were prescribed at the hospital?

___ pain medication ___ muscle relaxers ___ brace ___ other: _____

41. Please list any other medications you are taking with dose/frequency.

_____

_____

42. Did you receive any stitches for any cuts at the hospital? No ___ Yes ___ If yes, which area of the body?

_____

43. Were x-rays taken at the hospital? Yes ___ No___ If yes, which area of the body_____

44. Was an MRI or other study performed? Yes ___ No ___ If yes, which area of the body _____

45. Please list facility where images were taken, if applicable _____

INJURY INFORMATION:

46. What is injured from your accident/incident? _____

_____

47. Where does it hurt? Left? Right? Both sides? Other? _____

48. How would you describe your problem? Please circle all that apply.

Sharp	Shooting	Burning	Numb	Tingly
Dull	Achy	Sharp with Motion	Shooting with Motion	Stabbing with Motion

Other:_____

49. How often do you have this problem?

Constantly (75-100% of the time)	Frequently (50-75% of the time)	Occasionally (25-50% of the time)	Intermittently (Less than 25% of the time)

50. How would you rate the severity of your problem?

Mild	Moderate	Severe

51. Does your pain radiate anywhere in your body? If yes, please describe_____

_____

52. Do you have pain at night? If yes, please describe _____

_____

53. What makes your problem worse? Please circle all that apply.

Always there	Gardening	Shoveling	Standing up	Yard Work
Bending	Working Out	Sitting	Standing (long time)	Weather Changes
Driving	Lifting Objects	Sleeping	Stress	While at Work
Flexing/extending	Painting	Climbing Stairs	Computer Work	Sports:

Other, describe_____

54. What makes your problem better? Please circle all that apply.

Adjustments	Heat	Ibuprofen	Standing	Warm Bath
Bending Forward	Ice	Tylenol	Stretching	Nothing
Exercising	Massage	Rx Pain Medication	TENS/Muscle Stim	
Pain Relieving Cream	Muscle Relaxer	Resting	Walking	

55. Who have you seen for this problem? Please circle all that apply.

Chiropractor	ER Doctor	Massage Therapist	Physical Therapist
Neurologist	Orthopedist	Primary Care Doctor	No One

When and where? _____

For each of the conditions listed below, place a ✓ in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a ✓ in the "present" column.

PAST	PRESENT	SYMPTOM	PAST	PRESENT	SYMPTOM	PAST	PRESENT	SYMPTOM
		Headache			Rheumatoid Arthritis			Gallbladder disorder
		Neck pain			Cancer			Hepatitis
		Upper back pain			Benign tumor			Ulcer
		Mid back pain			Asthma			General fatigue
		Low back pain			Chronic Sinusitis			Visual disturbances
		Shoulder pain			High blood pressure			Dizziness
		Elbow/upper arm pain			Heart attack			Ringing in the ears
		Wrist pain			Chest pains			Diabetes
		Hip pain			Kidney stones			Frequent urination
		Upper leg pain			Kidney disorder			Drug dependence
		Knee pain			Bladder infection			Alcohol dependence
		Ankle/foot pain			Prostate problems			Depression
		Jaw pain			Weight gain/loss			Anxiety
		Joint pain/stiffness			Abdominal pain			Lupus
		Arthritis			Liver disorder			Epilepsy/seizures
		Loss of Sleep			Heartburn			Eczema/rash

Other_____

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

Tuberculosis	F	M	S	B	Cancer	F	M	S	B	Mental Illness	F	M	S	B
Diabetes	F	M	S	B	Asthma	F	M	S	B	Heart Disease	F	M	S	B
Arthritis	F	M	S	B	Kidney Disease	F	M	S	B	Lung Disease	F	M	S	B
Stroke	F	M	S	B	Liver Disease	F	M	S	B	Headaches	F	M	S	B
Low back pain	F	M	S	B	Neck Pain	F	M	S	B	Migraines	F	M	S	B

Other_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? **Yes** or **No** If yes, how much per week? _____

Have you ever used tobacco? **Yes** or **No** If yes, how much per day: _____

If a former tobacco user, date you quit _____

FEMALES ONLY: When was your last menstrual cycle? _____

Are you pregnant? No _____ Not Sure_____ Yes _____ Due Date: _____

Please ✓ if any of the following apply:

PAST	PRESENT	
		Birth control pill/patch, shot etc. Please specify:
		Hormone replacement: Describe
		Loss/termination of pregnancy:

Do you participate in any sports? Please circle all that apply.

Aerobics	Skiing	Basketball	Soccer	Baseball
Bicycling	Swimming	Football	Tennis	Golf
Lacrosse	Volleyball	Hockey	Walking	Softball
Running	Working Out	Martial Arts	Yoga/Pilates	Triathlons

Other_____

List any nutritional supplements you are taking (vitamins, herbs, naturopathic remedies, etc) _____
_____

Please list all surgical/hospitalizations you have had, including dates_____
_____
_____
_____

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

Have you had any PAST trauma (example: auto accident, work injury, broken bones/stitches)? Include dates:
_____
_____

Have you been treated for any health condition/any **other** health problems (no matter how insignificant they may seem be) by a physician in the last year? **Yes** or **No**

If yes, describe: _____

PREVIOUS CHIROPRACTIC HISTORY Have you had any previous chiropractic care? Yes or No Clinic Name/Doctor: _____ When was your last adjustment: #_____Year(s) #_____Month(s) #_____Week(s) #_____Day(s)

PATIENT'S SIGNATURE: _____ DATE: _____

GUARDIAN'S SIGNATURE AUTHORIZING CARE: _____ DATE: _____

DOCTOR'S SIGNATURE: _____ DATE: _____

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.

_____ _____

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

_____ _____

GUARDIAN/SPOUSE SIGNATURE TO AUTHORIZE CARE **DATE**

FINANCIAL POLICY

MISSED APPOINTMENT: Your time is important, as is ours. A $50.00 fee will be charged to all accounts that miss an appointment without 24-hour notice. All cancellations and reschedules must be made by calling or texting. NO emails. This is not a fee that can be submitted to your insurance.

INSURANCE: Current insurance MUST be present at the time of service. All claims will be submitted to your insurance carrier unless otherwise specified. Great Lakes Chiropractic will not go back to correct claims processing because of missing or invalid insurance for primary or secondary policies. We will not 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 am also 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 to me will be immediately due and payable.
In the event your insurance does not process a claim, or they reverse previously processed claims for any reason, we will not go back more than 90 days to re-submit claims. You will be financially responsible for the self-pay office visit rate for all appointments older than 90 days.

INSURANCE POLICY HOLDER'S FIRST AND LAST NAME | RELATIONSHIP TO PATIENT | POLICY HOLDER'S DOB

WHO HAS FINANCIAL RESPONSIBLE FOR THIS PATIENT | RELATIONSHIP TO PATIENT

COPAYS AND BALANCES: Co-payments AND/OR any balance on your account are due on the day of your appointment.

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

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.

SELF-PAY RATE/NO INSURANCE: 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 self-pay office visit. This charge will be due at the time of your appointment.

CARD-ON-FILE: All accounts are required to have a credit card on file to cover fees, co-pays, co-insurance and deductibles. See separate form.

COLLECTIONS: Unpaid balances of five months or more will incur an 8% of the outstanding balance late fee per month. After nine months, the account will be turned over to a collection agency.

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

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

AUTHORIZED PEOPLE WHO HAVE ACCESS TO MY INFORMATION

I authorize Great Lakes Chiropractic of St. Michael to share my account information including TREATMENT DETAILS, ACCOUNT INFORMATION, PAYMENT DETAILS, AND APPOINTMENT TIMES with the following people. (spouse, parent, children)

_____ _____
NAME RELATIONSHIP TO PATEINT

_____ _____
NAME RELATIONSHIP TO PATEINT

_____ _____
NAME RELATIONSHIP TO PATEINT

☐ **Please do NOT allow anyone to access my information**

This is valid until revoked or changed by written communication.

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

AUTHORIZED CARD-ON-FILE

I am providing Great Lakes Chiropractic of St. Michael with a credit card to be stored securely and used for all fees, co-pays, and/or co-insurance or deductibles after insurance has processed my claims. The card on file can be changed or removed at any time by contacting Great Lakes Chiropractic of St. Michael.

_____ The card-on-file will only be used in these situations:
(Initial)

a) **when authorized by you to pay your balance**
b) **automatically when you have a past due balance of over 60 days**
c) **automatically for a missed appointment fee**
d) **automatically when you cancel/reschedule an appointment with less than 24-hour notice**

I agree to respond promptly when Great Lakes Chiropractic of St. Michael notifies me that my card-on-file does not work or has expired.

This card-on-file can be used for the following people or family members:

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship

_____ _____
SIGNATURE DATE

Security note from Rectangle Health, the credit card processing software vendor:
"All cards are electronically stored and encrypted in the payment portal software, such that no direct staff at Great Lakes Chiropractic or support staff at Rectangle Health can view your information at any point, beyond the last 4 digits. Once imbedded into the software the information is encrypted and stored."

AUTHORIZATION TO CONSENT TO TREATMENT

Dear Parent(s): State law requires that you consent to most medical treatments for your minor child. If an adult other than your child's parent or legal guardian accompanies him/her to office visits or your child is of legal driving age and will be coming to appointments without you, we will be unable to provide treatment without your written authorization, except in emergency situations. To authorize an adult other than your child's parent or legal guardian to consent to medical treatment for your child or for your child to attend visits without you, please complete the sections below. By completing this authorization, you consent to the sharing of your child's protected health information with this individual as outlined in our Notice of Privacy Practices.

PART I. MINOR CAN BE TREATED WITH CONSENT FROM OTHER ADULT

I authorize the following individual(s):

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

to consent to medical treatment for my minor child(ren) listed below:

Name: _____ Date of birth: _____

PART II. MINOR CAN BE TREATED WITHOUT PARENT PRESENT

I authorize my child(ren) of legal driving age to attend appointments on their own. Consent for care is still required by a legal guardian.

Name: _____ Date of birth: _____

PART IV. SIGNATURE

_____
Printed Name of Parent or Legal Guardian

_____ _____
Signature of Parent or Legal Guardian Date