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

**WORKER'S COMP INTAKE**
New Patient


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:**

Insurance Company: _____

Adjuster's Name: _____

Adjuster's Phone Number: _____

Claim #: _____

**ACCIDENT INFORMATION:**

Date of the injury: _____/_____/_____

Time of the injury: _____ AM / PM

Name of your employer: _____

Address of your employer: _____

Describe the incident in a few sentences:

_____

_____

_____

Did you report the incident to your supervisor? Yes ___ No ___

Supervisor's name: _____

Did your employer send you to a doctor? No ___ Yes ___ If yes, please provide the doctor's name

_____

Did you go to a doctor on your own? No ____ Yes ___ If yes, please provide the doctor's name

_____

Were any images taken? No____ Yes____ Circle all that apply.

X-ray MRI CT Ultrasound

Please list what part of the body images were taken: _____

Name of the facility the images were taken at: _____

Are there any other problems that affect your employment? No ____ Yes ____ If yes, please explain:

_____

_____

Does your job cause you to favor one side of your body? No ___ Yes ____ If yes, please explain: _____

_____

Before the injury, were you capable of performing equal work with others your age? Yes ___ No ____

Have you injured this area before? Yes ____ No ___ If yes, please explain: _____

_____

_____

**INJURY INFORMATION:**

What is injured from your accident/incident? _____

_____

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

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:_____

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) |

How would you rate the severity of your problem?

| | | |
|---|---|---|
| Mild | Moderate | Severe |

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

_____

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

_____

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_____

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 | |

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? _____ No _____Yes 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? _____ No _____ Yes If yes, describe: _____
_____

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 |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

_____ _____
SIGNATURE TODAY'S 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."*