Date Name		Age Birth	n Date
Email	Social Security #		Marital Status: M S W D
Race/ethnicity	La	inguage Preference	
Address	City		StateZip
Home Phone	Work Phone	Cell Ph	none
Occupation	Emplo	yer	
Name of Spouse/Guardian	S	pouse/Guardian Phon	ne
Spouse's Employer		Occupation	
Names and Ages of Children			
Emergency Contact			
Family Medical Doctor/Clinic			
How were you referred to our of	fice?		
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:			

Page 2



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: _____

WORKER'S COMP INTAKE

New Patient Page 3

IN	JURY INFORMAT	ION:						
W	hat is injured from	your acci	dent/incident? _					
	here does it hurt?				annly			
	Sharp	Shooting		urning		Numb		Tingly
	Dull	Achy		vith Motion	Shootii	ng with Motion	St	abbing with Motion
Ot	her:					0		
Нс	w often do you ha		oblem?					
	Constantly		Freque	•		ccasionally		Intermittently
	(75-100% of the	e time)	(50-75% of	the time)	(25-50	% of the time)	(Les	s than 25% of the time)
	. 1.1			2				
HC	w would you rate	tne sever ild	ity of your probi					Cavana
Į	IV	IIa		IVIOU	erate			Severe
D =		مارین دی می می		Olfwaa alaaa	م ما دم ما دم			
DC	es your pain radia	te anywn	ere in your body	r ii yes, piease	e describe_			
Da	vyou havo nain a	t niaht2	If you please d	oscribo				
DC	you have pain a	t Hight!	ii yes, piease u	escribe				
۱۸/	hat makes your pro	hlom wo	rco2 Dloaco circl	o all that annly	,			
VV	Always there		Gardening	Shoveli		Ctandingun		Yard Work
	Bending		Vorking Out	Sittin		Standing up Standing (long time	۵۱	Weather Changes
	Driving		fting Objects	Sleepii		Stress	-)	While at Work
	Flexing/extendin		Painting	Climbing		Computer Work	Sr	oorts:
Ot	her, describe	8	i diriting	Cilitioning .	otali 5	compater work	21	50113.
•								
W	hat makes your pro	blem bet	tter? Please circl	e all that apply	٧.			
	Adjustments		Heat		rofen	Standing		Warm Bath
	Bending Forward	ı	Ice		enol	Stretching		Nothing
	Exercising		Massage	Rx Pain N	1edication	TENS/Muscle S	Stim	
	Pain Relieving Crea	ım l	Muscle Relaxer	Res	ting	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? _____

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Other__

PAST

PRESENT

WORKER'S COMP INTAKE

New Patient Page 4

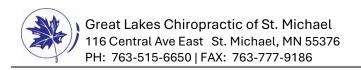
For each of the conditions listed below, place a \checkmark in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a \checkmark in the "present" column.

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

Tuberculosis	F	М	S	В	Cancer	F	М	S	В	Mental Illness	F	М	S	В
Diabetes	F	М	S	В	Asthma	F	М	S	В	Heart Disease	F	М	S	В
Arthritis	F	М	S	В	Kidney Disease	F	М	S	В	Lung Disease	F	М	S	В
Stroke	F	М	S	В	Liver Disease	F	М	S	В	Headaches	F	М	S	В
Low back pain	F	М	S	В	Neck Pain	F	М	S	В	Migraines	F	М	S	В
No you drink alcoholic beverages? Yes or No If yes, how much per week?														
a former tohaco	م راد	er d:	ate v	ou quit										
a former tobacco user, date you quit														
EMALES ONLY: When was your last menstrual cycle?														
EMALES ONLY: V	re you pregnant? No Not Sure Yes Due Date:													
)		Not Sure	Yes		Due	Date	e:					

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, na	aturopathic remedies, etc)
Please list all surgical/hospitalizations you have had, including date	
Do you have allergies of any kind? NoYes If yes, des	cribe:
Have you had any PAST trauma (example: auto accident, work inju	······································
Have you been treated for any health condition/any other health pe) by a physician in the last year? No Yes If yes, de	roblems (no matter how insignificant they may seem
PATIENT'S SIGNATURE:	DATE:
GUARDIAN'S SIGNATURE AUTHORIZING CARE:	DATE:
DOCTOR'S SIGNATURE:	DATF:

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	
, , ,	•	•	a specific cure or result. I understa ent risk. Given this information, I	
SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY, IF	DATE		

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WORKER'S COMP INTAKE

New Patient Page 7

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
INCLIDANCE DOLLOW HOLDER'S FIRST AND LAST MANAGE	DELATIONICHID TO DATIENT	DOLLOV HOLDER'S DOD

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.

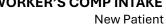
I have read and understand the Financial Policy of Great Lakes Chiropractic of St. Michael. I understand that I am responsible for all services not paid for by my insurance including deductibles, copayments, or non-covered services. I am also responsible for any fees incurred.

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

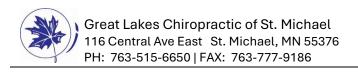
AUTHORIZED PEOPLE WHO HAVE ACCESS TO MY INFORMATION

DETAILS, ACCOUNT INFORMATION, PAYMENT DETAILS, AND APPOINTM (spouse, parent, children)	1ENT TIMES with the following people.
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

I authorize Great Lakes Chiropractic of St. Michael to share my account information including TREATMENT



Page 9



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
<mark>SIGNATURE</mark>	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."