Southwest Family Chiropractic
100 E US Hwy 14
Tyler, MN 56178 507-247-3249

Patient Information

Date:

Name _____ (Last) _____ (First) _____ (M.I.)

Birthdate _____ Age _____ Sex _____

Street Address _____ Apartment _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Mobile _____

Email Address _____ Marital Status ☐ Single ☐ Married

Occupation _____ ☐ Divorced ☐ Widowed

Height Inches: Weight Lbs How many children do you have? _____

Parents Names: (if a minor) _____

How did you hear about our office? _____

Have you been to a chiropractor in the past? ☐ Yes ☐ No Name

Patient Health History

X-rays Dates: _____

MRI, CT, or Bone Scan Dates: _____

Are you taking any of the following medications? ☐ Antibiotics ☐ Pain Killers ☐ Stimulants ☐ Vitamins or Supplements ☐ Antidepressants ☐ Insulin ☐ Other (s)

_____

Place a mark on "Yes" or "No" to indicate if you have had or are experiencing any of the following:

Acid reflux/Heartburn	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No
ADHD/ ADD	☐ Yes ☐ No	Excessive Appetite	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Aids/HIV	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Prostate Issues	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Frequent Urination	☐ Yes ☐ No	Rheum. Arthritis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Ringing in ears	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Heart Conditions	☐ Yes ☐ No	Sinus Condition	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Sleeping Issues	☐ Yes ☐ No
Backaches	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Tension	☐ Yes ☐ No
Concussion	☐ Yes ☐ No	Loss of Hearing	☐ Yes ☐ No	Thyroid Issues	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Other Headaches	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Mood Swings	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Digestive Issues	☐ Yes ☐ No	Neuritis	☐ Yes ☐ No	Weight Loss	☐ Yes ☐ No
Dizziness/Vertigo	☐ Yes ☐ No	Numbness	☐ Yes ☐ No	ADD/ ADHD	☐ Yes ☐ No
Difficulty Sleeping	☐ Yes ☐ No			Other:	
Ear Infections	☐ Yes ☐ No				

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking
☐ Alcohol
☐ Coffee/Caffeine Drinks
☐ High Stress

FLUID INTAKE
☐ Pop
☐ Energy Drinks
☐ Water
☐ Milk

SLEEP
☐ Back
☐ Side
☐ Stomach
☐ Recliner

Females: ☐ Pregnancy ☐ Menstrual Pain ☐ Menstrual Irregularity ☐ Hot Flashes

Males: Do you carry your wallet in your ☐ Front Pocket ☐ Back Pocket or ☐ Other

Your Concerns

What is your major complaint or concern? _____

How long have you experienced this? _____

Are the symptoms ☐ Getting worse? ☐ Getting better?

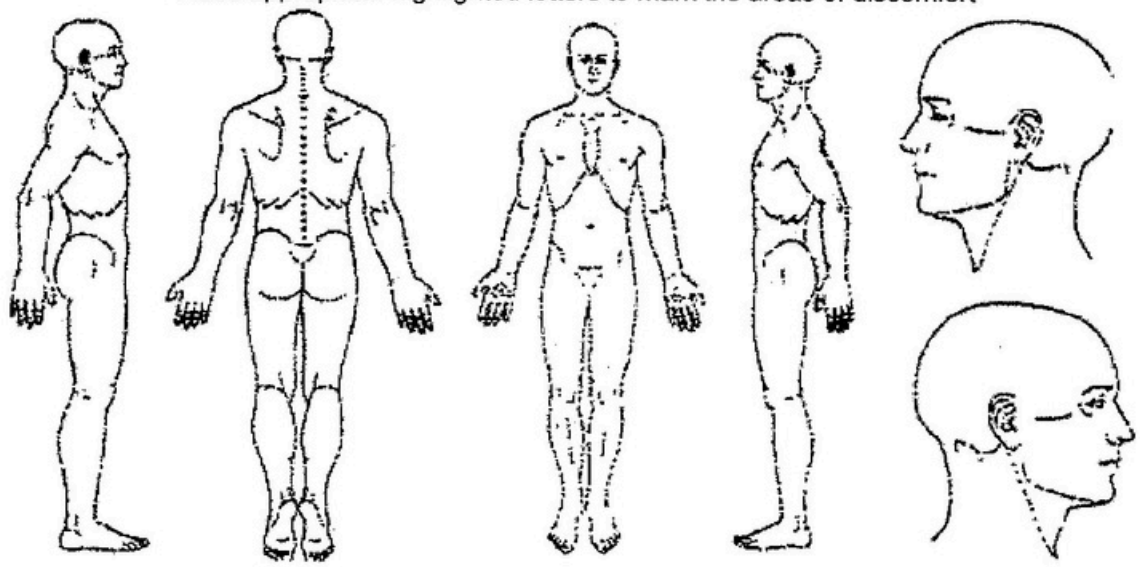
What treatment have you already received for your condition? ☐ Chiropractic ☐ Surgery
☐ Physical Therapy ☐ Medical Doctor ☐ None ☐ Other _____

Other doctor(s) that treated for this condition: _____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain) _____

Type of pain:
☐ **S**harp ☐ **N**umbness ☐ **Th**robbing ☐ **A**ching ☐ **Sh**ooting
☐ **B**urning ☐ **D**ull ☐ **T**ingling ☐ **St**iffness ☐ **O**ther

Place appropriate highlighted letters to mark the areas of discomfort



How often do you have this pain? _____

Does it interfere with School ☐ Sleep ☐ Daily Routine ☐ Recreation ☐

Activities or movements that are painful to perform:
Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐

Other comments or concerns regarding your condition: _____

_____

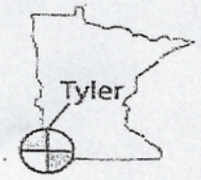
Authorization to treat a Minor

I, _____ the undersigning parent/guardian having legal custody/guardianship of _____, a minor do hereby authorize Dr. Determan and whomever he may designate as assistant to perform in judgement any examination and chiropractic diagnosis or treatment which is deemed necessary.

Any Specific written authorization you provide may be revoked at any time by writing to us at the address provided on the top of this form.

Patient Signature _____ Date _____

Guardian Signature _____ Date _____



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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree to how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient my request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily to those who do not need them.
6. Patients have the right to file a formal complaint with any privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care options, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient (please print) Date

_____

Signature of Patient or Patient's Guardian

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1. Terms of Acceptance

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

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
Health: The 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 of mental impulses, resulting in a lessening of the body's innate abilities to express its maximum health potential.

We do not offer diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. However, 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 those findings, we will recommend that you seek the serves of another health care provider.

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 OBJECTICE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

2. Financial Policy

Southwest Family Chiropractic (SWFC) submits claims to insurance companies listed below as a courtesy to our patients and asks that co-payments are made at the time of service. Patients are responsible for any portion not covered by insurance. SWFC accepts Medicare, Medicare supplements, Medical Assistance, workers compensation and auto accident insurance. Patients give SWFC authorization to release all medical records to insurance company when requested. All bills of unpaid ledger balances will be sent out by the 15th of each month. Payment from patient is required within 30 days of bill date. Payment from out-of-network patients and cash patients are to be paid at the time of service. I realize I am financially responsible for all charges, regardless of insurance coverage. This authorization is in effect until revoked in writing. A photocopy of this assignment is to be considered valid as an original.

_____ _____
(Signature) (Date)

(Over)

3. The Consent to Evaluate and Adjust a Minor Child

I, _____ being the parent or legal guardian of

_____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

4. Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant, and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of my last menstrual cycle _____.

_____ _____

(Signature) (Date)

5. Contact Information

It is sometimes necessary to contact you about appointments, test results, or general information. It is permissible to.....

Call me at home and/or leave me a message with anyone answering the home phone
Or leave a message on voice mail/answering machine.

_____Yes _____No

6. Emergency Information

Name: _____ Relationship_____

Address: _____ Home Phone_____

_____ Work or Cell Phone: _____