Quality Life Chiropractic & Massage

New Patient Case History

Patient Information

Name _____ Birth Date: _____ Age: _____ Sex: __ M __ F

Address: _____City / State / Zip: _____

Cell Phone: ( )_____ Home Phone: ( )_____ Work Phone: ( )_____

Email: _____ Occupation: _____

***We may contact you by text or email concerning your appointments or requesting feedback. Is this okay? _____Y _____N**

How did you learn about our office? Please circle one: Do you have **Medicare** Insurance?____ Y ____ N

*Referral Facebook Yelp Google Search Google Maps Yahoo Search Bing Search Shop Rochester Other _____

*If referral, who referred you? _____

Consent to Treat a Minor

I, the undersigned, hereby authorize and give consent for Quality Life Chiropractic & Massage to examine and administer treatment as necessary to my son/daughter, **Son/daughter's name: (please print)** _____.

Parent/Legal Guardian Print Name: _____ **Signature:** _____ **Date:** _____

Emergency Contact

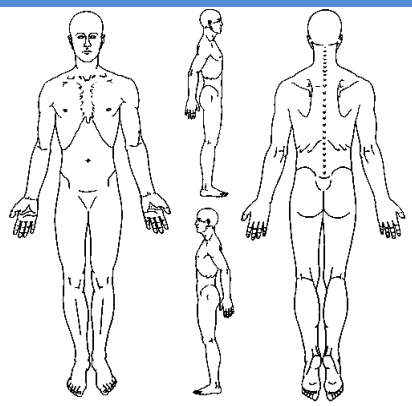
Name: _____ Relation: _____ City / State: _____

Home Phone:( )_____ Cell Phone:( )_____ Work Phone:( )_____

Major Complaint Information

Using the symbols provided in the Pain Index Box below, mark the areas on the illustrations to the right where you are experiencing symptoms, followed by a number from 1 to 10 indicating the extent of the pain. (1 being mild, 10 being severe)

Pain Index	
D	**Dull Ache**
B	**Burning**
S	**Sharp / Stabbing**
N	**Numbness / Tingling**



What is/are your major complaint(s)?_____

_____

When did this symptom(s) begin?_____

If you believe you know the cause, describe what happened? _____

Have you experienced these symptoms before? __Y __N When: _____

What aggravates this condition? _____

What relieves the symptoms/pain? _____

Does it cause pain to cough, grunt or sneeze? __Y __ N If so, where? _____

Does this condition interfere with your sleep? __Y __N If so, how many times do you wake up in pain per night? _____

In what position do you sleep? __ Back __ Right Side __ Left Side __ Stomach

Have you seen another doctor for this condition? __Y __N Doctor's name: _____ Date consulted:_____

Diagnosis:_____

Have you been x-rayed in the past 12 months? __Y __ N Where: _____ Date: _____

Have you ever been seen by a chiropractor? __Y __N Most recent Chiropractor: _____ Date: _____

Check those activities below during which you experience difficulty or pain:

___ Lying on back	___ Getting in /out of car	___ Pulling	___ Sitting	___ Standing for long periods
___ Lying on side	___ Dressing Self	___ Reaching	___ Bending Forward	___ Sneezing
___ Turning over in bed	___ Kneeling	___ Bending Backward	___ Coughing	___Other:_____
___ Lying flat on stomach	___ Pushing	___ Stooping	___ Walking	___Other:_____

Lower Back Pain

Does pain radiate into your leg(s)? __ Y __ N Where? _____ Does pain radiate to the abdomen? __ Y __ N

Has this pain caused an impairment of bowel or urinary function? __ Y __ N Explain: _____

Do you have numbness or tingling into the legs? __ Y __ N Explain: _____

Neck Pain

If you have a neck injury, does it affect: (Check all that apply) __ Hearing __ Vision __ Balance __ Cause ringing in your ears

Do you hear grating sounds? __ Y __ N Do you feel pressure or pain behind your eyes? __ Y __ N

Does pain radiate into the arm(s)? __ Y __ N Where: _____

Do you have difficulty lifting or turning your head? __ Y __ N If so, in which direction? __ Right __ Left __ Up __ Down

Headaches

Do you get headaches? __ Y __ N Frequency _____ Do you have a family history of headaches? __ Y __ N

Check all of the following that you experience along with your headaches:

__High Blood Pressure __ Low Blood Pressure __ Nausea __Vomiting __Visual Disturbances __ Pain in your Jaw __ Cracking in your Jaw

When was your last eye exam by a doctor? __ 1 – 6 months __ 6 – 12 months 1 – 2 years __ over 2 years Results: _____

Medical History

If female, **are you pregnant? __ Y __ N __ Not Sure** Date of last menstrual period: _____

Any allergies? __ Y __ N __ Not Sure Please list: _____

_____

List all medications you are currently taking, include over-the-counter medications: _____

_____

_____

Do you currently take supplements? __ Y __ N Please List:_____

_____

Do you have any dietary conditions or restrictions? __ Y __ N Explain: _____

_____

Have you ever had any surgeries or hospitalizations? __ Y __ N

Type of Hospitalization / Surgery _____ Date: _____

Type of Hospitalization / Surgery _____ Date: _____

Type of Hospitalization / Surgery _____ Date: _____

Do you have a family doctor? __ Y __ N Name of doctor: _____

Phone: _____ Clinic Name: _____ City / State: _____

Any additional complaints, diseases, medical problems or information not listed? Please list: _____

_____

_____

Have you ever had: __ Motor Vehicle Injury __ Sports Injury __ Work Injury __ Slip & Fall Injury

If yes, please explain: _____

_____

Informed Consent for Treatment

I hereby authorize physicians and staff at Quality Life Chiropractic & Massage to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct and to the best of my knowledge. I will not hold my doctor or any staff member at Quality Life Chiropractic & Massage responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:
Soreness – Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.
Soft Tissue Injury – Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft-tissue injury.
Rib Injury – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is preformed carefully to minimize such risk.
Stroke – Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical manipulations.
Other Problems – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.
Having carefully read the above, I hereby give my informed consent to have the chiropractic treatment administered.

Patient / Legal Guardian Signature: _____ Date: _____

HIPPA Notice of Privacy Practices

THE NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Each time you come in for care, we create a record of treatment and services provided to you in this office. We are required by law to keep all of your medical information private and make available to you, the patient, information regarding your rights, your medical information and our legal duties and privacy practices. The Notice of Privacy Practices describes how medical information about you may be used and disclosed, and how you can get access to this information.

I, _____ have been presented with the Notice of Privacy Policy for Quality Life Chiropractic & Massage.

A copy of the HIPPA Notice of Privacy Practices is also available on our website, www.qualitylifemn.com.

_____ I wish to receive a copy of the HIPPA Notice of Privacy Practices at this time. _____ Initials of staff member presenting notice.

_____ I **do not** wish to receive a copy of the HIPPA Notice of Privacy Practices at this time but I remain the right to receive a copy at anytime.

Patient / Legal Guardian Signature: _____ Date: _____

Quality Life Chiropractic & Massage

Workers Compensation / Auto Accident / Personal Injury

Date of Accident: _____ Time: _____ __ AM __ PM Location: _____

How did the accident occur? __ Auto Collision __ On-the-Job Injury __ Other:_____

Please describe the accident or injury: _____

_____

_____

If work related , Employer's Name: _____City / State: _____

If auto accident, were you the: __ Driver __ Passenger __ Pedestrian

If auto collision, were you struck from: __ Behind __ Right Side __ Left Side __ Front __ Vehicle was parked __ Other:_____

If auto accident, did your vehicle strike the other(s) involved? __Y __N

Did the other vehicle strike yours? __Y __ N __Undetermined

Did your airbag deploy? __ Y __ N Were you wearing a seatbelt? __ Y __ N

Did your body strike any objects in the vehicle? __ Y __ N Please list objects: _____

Did you lose consciousness from the accident? __ Y __ N Did Police / Ambulance / Fire respond to the accident? __ Y __ N

Were you taken to the hospital following the accident? __ Y __ N Was a report filed on the accident? __ Y __ N

Was work time lost due to the accident? __ Y __ N If yes, date you returned to work: _____

Do you have an attorney who has advised you in this case? __ Y __ N Attorney's Name: _____

Attorney's City/Sate: _____ Attorney's Phone #: ( ) _____ Ext:_____

Claim #:_____ Social Security #:_____

Name of Insurance:_____

Claim Adjuster's Name: _____ Claim Adjuster's Phone #: ( ) _____Ext: _____

Medicare / Workers Compensation / Auto Accident / Personal Injury - Authorization & Assignment of Benefits

I authorize Quality Life Chiropractic & Massage to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts Quality Life Chiropractic & Massage does not collect from insurance proceeds (whether it be all or part of what is due) I personally owe.

I the undersigned do hereby appoint Quality Life Chiropractic & Massage authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Patient / Legal Guardian Signature: _____ **Date:** _____