



NEW PATIENT ENTRANCE APPLICATION

Welcome! We are honored you chose us to evaluate your condition. So we may file your insurance forms for you, would you please fill out the personal information below? If you need assistance please inform the front desk person. Thank you!

Personal Information:

Patient Name: _____ Date: _____
Date of Birth: _____ Age: _____ Sex: M or F _____ Marital Status: S M D _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____
Social Security #: _____ E-mail: _____
Employer Name: _____ Occupation: _____
Emergency Contact: _____ Relationship: _____ Phone #: _____

Guardian / Spouse / Family Information:

Name: _____ Relationship: _____
Employer Name: _____ Occupation: _____ Phone #: _____
Children:
Name: _____ Age: _____ Sex: M or F _____ Name: _____ Age: _____ Sex: M or F _____
Name: _____ Age: _____ Sex: M or F _____ Name: _____ Age: _____ Sex: M or F _____
Name: _____ Age: _____ Sex: M or F _____ Name: _____ Age: _____ Sex: M or F _____

Referral Information:

- How did you find out about us _____
- Primary Care Physician (Name & Location) _____

Patient Informed Consent:

I, <print name>, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature: _____ **Date:** _____



CHIROPRACTIC PATIENT HISTORY

So that we may better understand your unique condition, please complete the following information with regard to your current complaint.

Location:

What Is Your Primary Complaint? _____

What Caused The Onset? _____

When Did It Start? ____ / ____ / ____

Does the Complaint Radiate or Travel? If so, Where? _____

Timing and Duration:

- ✓ Since the onset of your complaint how has it been changing? Getting Better Not Changing Getting Worse
- ✓ How often do you experience this complaint? Constantly (100%) Frequently (75%) Occasionally (50%) Intermittently (25%)
- ✓ Does your complaint worsen? If so, When? Morning Midday Night Sleep Work Other: _____
- ✓ How much has the complaint interfered with your normal work? (including both work outside the home, and housework)
 - Not at all A little bit Moderately Quite a bit Extremely
- ✓ How much would you say this complaint has affected your social activities?
 - All of the time Most of the time Some of the time A little of the time None of the time

Severity:

Use the key below to rate the severity of your pain.

0 = No Pain 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate 6 = Moderate to Severe
7 = Mildly Severe 8 = Severe 9 = Very Severe 10 = Excruciating

Please circle where you rate your pain: 1 2 3 4 5 6 7 8 9 10

Quality:

- ✓ How would you describe the sensation of your complaint?
 - Sharp pain Shooting Numbness Tingling
 - Dull Ache Burning Throbbing Other: _____

Modifying Factors:

- ✓ What makes your complaint feel worse?
 - Coughing / Sneezing Standing Lifting Exercising Bending Twisting
 - Pushing / Pulling Sitting Walking Driving Climbing Other: _____

Alleviating Factors:

- ✓ What makes your complaint feel better?
 - Rest / Sleep Stretching Lifting Exercising Bending Twisting
 - Pain Medication Ice Heat Shower Walking Other: _____

Previous Treatment:

Who have you seen for this condition? Medical Doctor Physical Therapist Chiropractor Other: _____

Have you had Chiropractic care in the past? Yes No If so, When? ____ / ____ / ____

Risk Factors:

- Do you have a pace maker? Yes No Are you pregnant? Yes No Maybe
- Do you have any metal implants or devices? Yes No

History was obtained from: Patient Parent Guardian Child Other: _____

Patient / Guardian Signature: _____ Date: _____

Dr: _____



PAST AND GENERAL HISTORY

To help us better understand your unique condition please complete the information below related to your past and general history.

Past History: Please Mark Below With an "X"

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition	Past	Present	Allergies
X		Example	X	X	Example		X	Example	X	X	Example
		Angina / Chest Pain			Heart Problems			Seizures			Animal Dander
		Arthritis			HIV			Sleeping Problems			Latex
		Asthma			Irritability			Soreness			Food Allergies
		Back Pain			Joint Stiffness			Speaking Problems			Penicillin
		Balance Problems			Joint Swelling			Spinal Curvature			Pollen
		Broken Bones			Joint Tenderness			Stiffness			Smoke
		Cancer			Loss of Sleep			Stroke / TIA			Grasses
		Chills			Lumps			Tingling			Sulfa Drugs
		Concentration Loss			Masses			Thyroid Problems			Dairy Products
		Diabetes			Memory Loss			Tremors			Perfumes
		Dizziness			Muscle Cramps			Vertigo			Hay
		Fatigue			Muscle Pain			Weakness			Other Please List:
		Fainting			Nervousness			Other Please List:			
		Fever			Night Sweats						
		Gout			Numbness						
		Headaches			Paralysis						

Medication and Surgical History:

Surgery	Yes	No	Year	Surgery	Yes	No	Year	Have You Ever Taken:	Yes	No	Year
Tonsils				Women				Insulin			
Colon				Breast				Cortisone			
Hernia				Uterus				Thyroid Medication			
Appendix				Ovaries				Male / Female Hormones			
Gall Bladder								Blood Pressure Medication			
Stomach				Men				Cholesterol Medication			
Heart				Prostate				Anti-Depressants			
Kidney								Tranquilizers / Sedatives			
								Birth Control			

What Other Supplements, Vitamins or Medications Are You Taking? _____

Injury History:

What, If Any, Major Injuries Have You Had? When? _____

Have You Been Hospitalized? If so, When and Why? _____

Patient / Guardian Signature: _____ Date: _____

Dr: _____



SOCIAL AND FAMILY HISTORY

In an effort to provide you with the best care possible, please take a moment to answer the following questions related to your social history, daily activities and family history.

Social History:

- ✓ **What Is The Highest Level of Schooling You Have Completed?**
 Still in School Some High School High School Some College College Graduate School
- ✓ **What Is Your Current Work Status?**
 Employed Full Time Employed Part Time Retired Unemployed Disabled Student
- ✓ **How Often Do You Exercise?**
 Never 1-3 times per month 1-2 times per week 3-4 times per week daily
- ✓ **How Would You Rate The Intensity Of Your Exercise?**
 Never Exercise Low Level Moderate Level High Level Competition level
- ✓ **How Many Hours Do You Sleep Per Night?**
 <4 hours 5-6 hours 7-8 hours 8-10 hours >10 hours
- ✓ **How Often Do You Eat A Balanced Diet?**
 Never Rarely Sometimes Regularly Always
- ✓ **How Often Do You Drink Caffeinated Beverages?**
 Never 1-3 Times Per Month 1-2 Times Per Week 3-4 Times Per Week Daily >2 Per Day
- ✓ **How Often Do You Smoke Cigarettes?**
 Never Past 1-3 packs per month 1-2 packs per week 3-4 packs per week >1 pack per day
- ✓ **How Often Do You Drink Alcohol?**
 Never Past 1-3 drinks per month 1-2 drinks per week 3-4 drinks per week daily
- ✓ **Have You Used Illicit / Street Drugs In The Past 6 Months?**
 Yes No

Daily Activities:

So that we may have an idea as to your daily routine please list a few of your daily activities and your favorite hobbies:

- ✓ **Does Your Current Condition Affect Your Performance In These Activities Or Hobbies?**

Yes No If So How: _____

Family History Information:

- ✓ **Please Indicate If Anyone In Your Family Currently Has, Or Has In The Past, Suffered From Any Of The Conditions Listed Below:**

✓ **Arthritis:**
 Yes No Whom: _____

✓ **High Blood Pressure:**
 Yes No Whom: _____

✓ **Back Pain:**
 Yes No Whom: _____

✓ **High Cholesterol:**
 Yes No Whom: _____

✓ **Cancer:**
 Yes No Whom: _____

✓ **Osteoporosis:**
 Yes No Whom: _____

✓ **Diabetes:**
 Yes No Whom: _____

✓ **Stroke:**
 Yes No Whom: _____

✓ **Heart Disease:**
 Yes No Whom: _____

✓ **Thyroid Conditions:**
 Yes No Whom: _____

Patient / Guardian Signature: _____ Date: _____

Dr: _____



SUMMARY OF NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT AND CONSENT
FOR PHI RELEASE

Privacy Policy:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) and specifically its Privacy Rule, I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that my PHI can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers that may be involved in my treatment directly or indirectly.
- Obtain payment or reimbursement from health coverage programs or others.
- Conduct normal healthcare business operations including routine aspects of operating a health related practice or business.

Acknowledgement and Consent:

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the creation, uses and disclosures of my PHI. I understand that West End Chiropractic has the right to change its Notice of Privacy Practices from time to time and that I may contact the Privacy Officer for West End Chiropractic at or through the address listed below to obtain a current copy of the Notice of Privacy Practices.

I also understand that I may request in writing that you restrict how my PHI is used or disclosed to carry out treatment, payment or healthcare operations. However, I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I further agree that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Privacy Officer Contact Information:

The privacy officer for West End Chiropractic may be contacted by mail by writing: Attn: 1660 Hwy 100 S, Ste 146 St. Louis Park, Mn 55416.

Office Use Only:

The following is practice documentation of our good faith effort to obtain acknowledgement of the above. Patient's acknowledgement of this notice could not be obtained due to the following situation:

- Patient Refused to Sign.
- Communication Barrier Prohibited Obtaining Acknowledgement.
- Emergency Circumstances
- Other: _____

Signature of Practice: _____

Date: _____

Patient Name (Please Print): _____

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



OFFICE POLICY

The following is a summary of our clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issue; regaining and maintaining your health. We are happy to answer any questions you have regarding your account.

Payment Policy:

- **Auto Accident and Workers Compensation:** If the incident is properly documented and the necessary forms and liens are signed, you are not required to pay for services on the day they are rendered and we will make efforts to file your services with your insurance provider for you. You are still responsible for all charges on your account. Any balance billed from our office deemed 'patient responsibility' exceeding 90 days past due will be assessed a 10.00% interest charge.
- **For patients with insurance:** West End Chiropractic will file your insurance claim for you, and will attempt to verify coverage of services to be performed. We will review this information with you and explain what services (if any) are not covered that you will be responsible for. You are responsible for the balance on your account for any professional services rendered if your insurance denies coverage. Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed a 10.00% interest charge. Payment plans are available, but you must contact our office to setup these plans. Additional Notes about insurance coverage:
 - Copays are due at the time of service.
 - You may be responsible for a Deductible Amount. This amount is deemed 'patient responsibility'. Our office will bill you for this amount following our offices receipt of an 'Explanation Of Benefits' (aka EOB) from your insurance company.
 - You may be responsible for a Coinsurance Amount. (aka % Responsibility) Our office will bill you for this amount following our offices receipt of an Explanation Of Benefits (aka EOB) from your insurance company.
 - You may choose to make payments in advance of receiving a bill for any amount considered patient responsibility.
- **For patients without insurance:** You have the option of paying in full on the date of service, paying in advance for your services or receiving a bill from our office. Discounts apply for payment in advance and payment made on the same day. You are responsible for the balance on your account for any services rendered. Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed a 10.00% interest charge.

Appointment Cancellation:

In order for us to better serve our growing number of patients, we ask that you please call if you will be late or unable to keep your scheduled appointment.

Emergency / After Hours Calls:

In case of an emergency you may contact our office during normal business hours for an appointment. Our office also has a doctor on call 24 hours which you may reach by pager. Should you require treatment during a non-treating time additional charges may apply.

Massage Policies:

- **Cancellation Policy:** If you cannot make your appointment we ask that you please contact our office 24 hours in advance to cancel. If your appointment is not cancelled 24 hours in advance it will be considered a 'No Show' and you will be subject to our 'No Show Policy.'
- **No Show Policy:** If you fail to cancel your appointment according to the cancellation policy you are considered a 'No Show' and will be unable to schedule your next appointment without providing payment in advance. If you fail to redeem this appointment time or fail to cancel according to the 'Cancellation Policy' you will surrender your payment for this appointment.
- **Refusal of Service Policy:** We reserve the right to refuse to provide services to any person at anytime. Should you be denied service you will be reimbursed for any unused services that have been paid in advance.

By signing below I acknowledge having received and read the above 'Office Policy.' I hereby agree to the terms and conditions outlined above.

Patient Name (Please Print): _____

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