ABOUT THE PATIENT

Health and Healing Family Chiropractic

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____Gender ❑ M ❑ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

e-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Emergency Contact _____ ph # _____

Name of Medical Doctor(s)_____

- I authorize the doctor or her staff to render care as deemed appropriate for me and / or my child.
- I authorize Health and Healing Family Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

_____

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

NOTES: _____

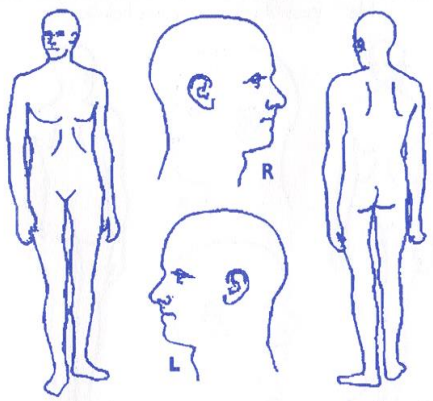
_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark All areas of concern.



GENERAL HEALTH HISTORY

Health and Healing Family Chiropractic

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. List any medications are you taking:_____

_____

2. Please list all doctors you are currently seeing: _____

_____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name_____

_____

_____

PAST HISTORY

4. List any past auto collisions:_____ Was any care received?_____
5. List any past work injuries: _____ Was any care received?_____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

PROVIDERS SEEN

List **all** providers seen since injury occurred:

1. Clinic/Doctor/Hospital Name_____City_____
2. Clinic/Doctor/Hospital Name_____City_____
3. Clinic/Doctor/Hospital Name_____City_____
4. Clinic/Doctor/Hospital Name_____City_____
5. Clinic/Doctor/Hospital Name_____City_____

❑ Yes ❑ No Do you have pictures of your vehicle? Where is it being repaired?_____

❑ Yes ❑ No Do you have a copy of the police report?

Name of your Attorney if you have one:_____

Name of Your Car Insurance Co._____ Name of Agent_____

Claim #_____ Phone #_____

Address of Your Car Insurance Co._____

Name of the Other Divers car Insurance if Applicable_____

COLLISION INFORMATION

Health and Healing Family Chiropractic

Name: _____Today's Date: _____

Where did the collision occur: Street:_____ City:_____State:_____

Date when collision occurred: _____ AM or PM. Was the road: ❑ Dry ❑ Wet ❑ Snowy ❑ Icy

Were you the: ❑ Driver ❑ Front middle passenger ❑ Front right passenger ❑ Back left ❑ Back middle ❑ Back right

Describe what happened:_____

_____

_____

_____

_____

CRASH DETAILS

❑ Yes ❑ No If driving, were both hands on the wheel at impact?

❑ Yes ❑ No If passenger, did your hands brace yourself?

❑ Yes ❑ No Did you have your seat belt and shoulder strap on?

❑ Yes ❑ No Was your seat up at the time of impact?

❑ Yes ❑ No Where you wearing a bulky coat or slippery pants?

❑ Yes ❑ No Did the seat belt engage?

❑ Yes ❑ No Did the airbag engage?

❑ Yes ❑ No Did you hit the dash, steering wheel or window?

❑ Yes ❑ No Did you know you were going to be hit?

❑ Yes ❑ No Did you brace yourself with hands or feet?

❑ Yes ❑ No If driving, was your foot on the brake at impact?

❑ Yes ❑ No Was your head turned at impact?

❑ Yes ❑ No Were you leaning forward?

❑ Yes ❑ No Did your glasses fly-off at impact?

❑ Yes ❑ No Was your body turned at the moment of impact?

❑ Yes ❑ No Did you get hit into another car, tree, railing, etc?

❑ Yes ❑ No Any damage or marks on your vehicle, the vehicle that hit you, or another object that was hit?

What part of the vehicle was hit? _____

1. What make and model of vehicle were you in?_____ The other vehicle?_____
2. What kind of seat were you in? __ Bucket __ Bench __ Fabric __ Leather/Vinyl
3. Did the car have headrests? ❑ Yes ❑ No
4. Did you hit your head on the headrest? ❑ Yes ❑ No On the back window if in a small truck? ❑ Yes ❑ No
5. Was the headrest positioned: __ below __ level with __ above the center of your head
6. Did your head hurt after the collision? ❑ Yes ❑ No Did your TMJ/jaw hurt after the collision? ❑ Yes ❑ No
7. How soon after the collision did you notice any pain? _____
8. Did the crash affect: ❑ dizziness ❑ memory ❑ concentration ❑ headaches ❑ balance ❑ nightmares ❑ breathing ❑ fatigue ❑ irritability ❑ ability to read ❑ ability to listen ❑ appetite ❑ nausea ❑ vision
9. Is there anything else you want us to know?_____

_____

Health & Healing Family Chiropractic
Karrie Lehn, DC Kerri Norring, DC

2705 Bunker Lake Blvd. Ste. 100
Andover, MN 55304
Phone: 763.323.0061
Fax: 763.754.9756

PREGNANCY RELEASE (all females must answer)

This is to certify that to the best of my knowledge I am not pregnant and Dr. Lehn, Dr. Norring, and their 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 last menstrual cycle: _____

PRINT NAME: _____ RELATIONSHIP TO PATIENT_____

PATIENT/PARENT OR LEGAN GUARDIAN SIGNATURE: _____

DATE: _____

FINANCIAL STATEMENT

Dear Patient:

Automobile Accidents and Worker's Compensation: For automobile accident,under Minnesota no-fault law and if/when your auto insurance carrier establishes liability; they will pay 100% of covered services directly to Health and Healing Family Chiropractic. For all insurances in this category, you are responsible for paying for any non-covered services, supplies or supplements which are due at the time the charges are incurred. In the event that your insurance denies liability or your benefits end, payment for services rendered becomes your responsibility.

I have read, understand and agree to abide by the information stated above as it applies to my coverage.

Printed Name_____

Signature_____Date_____

Please fill out your credit/debit card or your bank checking account information below.

Credit/Debit Card information

_____ _____
Name as it appears on Card Credit/Debit Card #

_____ _____
Security Code Expiration Date

Bank EFT information

_____ _____ _____
Bank Name Routing number Account Number

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Dr. Karrie Lehn
Dr. Kerri Norring

NOTICE OF DOCTOR'S LIEN

TO: Attorney _____
Address_____

RE: Medical Reports and Doctor's Lien

Client Name: _____ DOB: _____ DOI: _____

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him/her for medical service rendered me by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical and/or surgical benefits, including major medical, submitted by him/her for service rendered me and that this Agreement is made solely for said doctor's additional protection and in consideration of his/her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated: _____ Patient's Signature: _____

Witness: _____

ACKNOWLEDGEMENT OF ATTORNEY

The undersigned being attorney or record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above-named.

Dated: _____ Attorney's Signature: _____