ABOUT THE PATIENT

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: ______________________________

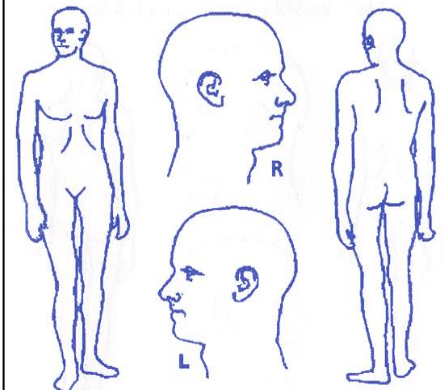
____

____

Are you pregnant?

❑ Yes ❑ No

Please mark All areas of concern.



GENERAL HEALTH HISTORY

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

Past	Present	Condition
❑	❑	Headaches
❑	❑	Migraines
❑	❑	Shortness of Breath
❑	❑	Allergies / Asthma
❑	❑	Medication Side Effects
❑	❑	Diabetes
❑	❑	Hands or Feet cold
❑	❑	Muscle aches
❑	❑	Trouble Walking
❑	❑	Leg / Foot Numbness
❑	❑	Fainting
❑	❑	Gall Bladder Trouble
❑	❑	Ringing in Ears
❑	❑	Ear Problems
❑	❑	Sleeping Problems
❑	❑	Vision Problems
❑	❑	Thyroid Problems
❑	❑	Liver Disease
❑	❑	Kidney Problems
❑	❑	Light Bothers Eyes

Past	Present	Condition
❑	❑	Urinary Problems
❑	❑	Easy Bruising
❑	❑	Tobacco Use
❑	❑	Dental Problems
❑	❑	Fibromyalgia
❑	❑	Blood Thinner use
❑	❑	HIV Positive
❑	❑	Cancer
❑	❑	Depression
❑	❑	Alcohol Use
❑	❑	___High or ___Low Blood Pressure
❑	❑	Stroke History
❑	❑	High Cholesterol
❑	❑	TMJ
❑	❑	Digestive Problems
❑	❑	Pain all Over
❑	❑	Tension / Irritability
❑	❑	Chest Pains
❑	❑	Heart Pacemaker
❑	❑	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?____

WORKER COMPENSATION INFORMATION

Health and Healing Family Chiropractic

Patient Information

Name:________________ Birthdate:________ Social Security #____________

Address:________________________

Home Phone: (____) ____________ E-mail:________________

Cell Phone: (____) ____________ Occupation:________________

Employer

Employer Name:________________________

Employer Address:________________________

Employer Phone: (____) ____________ Injury Verified by (For Office Use Only) ____________

Contact Person:________________ E-mail:________________

Worker Compensation Carrier (For Office Use)

Worker Compensation Carrier:________________________

Carrier Address:________________________

Carrier Phone: (____) ____________ Coverage Verified by:________________

Adjuster's Name:________________ Claim Number:________________

Injury Information

Date of Injury:________ Time:________ ❑ AM ❑ PM Place of Injury:________________

Accident reported to employer? ❑ Yes ❑ No Name of Person you reported accident to:________________

Give full description of how accident happened:________________________

____

____

Have you lost time from work? ❑ Yes ❑ No How much?________________

Other doctors seen for this condition: Doctor's Name________________

Diagnosis:________________ Were X-Rays taken? ❑ Yes ❑ No Other tests? ❑ Yes ❑ No

If yes, by whom? Please list test(s) and result(s) ________________

____

____

Any previous Worker Compensation injuries? ❑ Yes ❑ No Date(s) of previous injuries:________________

Describe previous Worker Compensation injuries:________________________

Authorization

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

Signature of Patient, Parent, Guardian or Personal Representative:________________ Date:________

Please Print Name:________________ Relationship to Patient:________________

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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