PATIENT HEALTH RECORD

Ada Chiropractic Clinic
406 E. Main St., Ada, MN 56510

ABOUT YOU

LAST NAME:	**FIRST NAME:**	**PREFERRED NAME:**	**BIRTHDATE:** / /
MAILING ADDRESS:	**CITY:**	**STATE/ZIP CODE:**	
HOME PHONE:	**CELL PHONE:**	**EMAIL ADDRESS:**	

ETHNICITY/RACE: ❑ AMERICAN INDIAN/ALASKAN NATIVE : ❑ ASIAN / AFRICAN AMERICAN : ❑ WHITE (CAUCASIAN)
❑ NATIVE HAWAIIAN OR PACIFIC ISLANDER : ❑ HISPANIC OR LATINO : ❑ OTHER : ❑ DECLINE TO ANSWER

HEIGHT: **WEIGHT:** **PREFERRED METHOD OF COMMUNICATION:** ❑ PHONE ❑ EMAIL ❑ MAIL

EMPLOYER NAME:		MARITIAL STATUS:	NUMBER OF CHILDREN:
EMPLOYER ADDRESS:		SPOUSE NAME:	
EMPLOYER CITY:	EMPLOYER STATE/ZIP CODE:	SPOUSE EMPLOYER:	
WORK PHONE:	POSITION TITLE:	POSITION TITLE:	

PAYMENT METHOD: ❑ CASH ❑ CHECK ❑ CREDIT CARD

MEDICATIONS

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ❑ NO ❑ YES

MEDICATION	DOSE & FREQUENCY	MEDICATION	DOSE & FREQUENCY

DO YOU HAVE ANY MEDICATION ALLERGIES? ❑ NO ❑ YES

PLEASE LIST:____

I WISH TO RECEIVE MY CLINICAL SUMMARY AFTER MY VISITS (These summaries are usually blank as a result of the nature and frequency of chiropractic care) **:** ❑ **NO** ❑ YES

PATIENT SIGNATURE:____ DATE:________________

For Office Use Only:

Blood Pressure: _____/_______ Pulse: ____________

REASON FOR THIS VISIT

PAIN DIAGRAM
On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: A – ACHE B – BURNING N – NUMBNESS
P – PINS & NEEDLES S – STABBING O - OTHER
X-- SHARP D - DULL

Pain Right Now: 0=No Pain 10= Worst Pain
0 1 2 3 4 5 6 7 8 9 10
Pain at it's Worst:
0 1 2 3 4 5 6 7 8 9 10
Pain at it's Best:
0 1 2 3 4 5 6 7 8 9 10

DESCRIBE THE REASON FOR THIS VISIT:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:
❑ JOB ❑ SPORTS ❑ AUTO ❑ FALL ❑ HOME INJURY
❑ CHRONIC DISCOMFORT ❑ OTHER
PLEASE EXPLAIN:

IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER?
❑ YES ❑ NO

WHEN DID THIS CONDITION BEGIN?

HAS THIS CONDITION:
❑ BECOME WORSE ❑ STAYED CONSTANT ❑ COME AND GONE

DOES THIS CONDITION INTERFERE WITH:
❑ WORK ❑ SLEEP ❑ DAILY ROUTINE ❑ OTHER ACTIVITIES
PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE?
❑ YES ❑ NO
PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION?
❑ YES ❑ NO

DOCTOR'S NAME:

TYPE OF TREATMENT:

RESULTS:

SYSTEMS REVIEW

INSTRUCTIONS: *Please check each of the diseases or conditions that you now have or have had in the past.*

CARDIOVASCULAR HEALTH: ❑ HIGH BLOOD PRESSURE ❑ LOW BLOOD PRESSURE ❑ AFRIBILLATION/ ARRYTHMIA ❑ PALPITATIONS ❑ CHEST PAIN
❑ HIGH CHOLESTEROL ❑ DIZZINESS ❑ DYSPNEA ❑ EXCESSIVE BRUISING ❑ SWELLING IN LEGS ❑ CONGENITAL HEART DISEASE ❑ OTHER?

RESPIRATORY HEALTH: ❑ ASTHMA ❑ SHORT OF BREATH ❑ EMPHYSEMA ❑ COUGH ❑ HAY FEVER ❑ APNEA ❑ PNEUMONIA
❑ WHEEZING ❑ MESOTHELIOMA ❑ OTHER?

GASTROINTESTINAL HEALTH: ❑ CONSTIPATION ❑ DIARRHEA ❑ ACID REFLUX ❑ IRRITABLE BOWEL SYNDROME ❑ GLUTEN INTOLERANCE
❑ ULCER ❑ FOOD ALLERGY ❑ BLOODY STOOL ❑ CROHN'S / COLITIS ❑ DIVERTICULITIS ❑ OTHER?

GENITOURINARY HEALTH: ❑ INCONTINENCE ❑ INCREASED FREQUENCY ❑ FREQUENT BLADDER INFECTIONS ❑ FREQUENT KIDNEY STONES
❑ PAINFUL URINATION ❑ URGENCY ❑ BLOOD IN URINE ❑ CHRONIC PROSTATITIS ❑ PAST PROSTATE CANCER ❑ OTHER?

ENDOCRINE HEALTH: ❑ TYPE I DIABETES ❑ TYPE II DIABETES ❑ HYPER-THYROID ❑ HYPO-THYROID ❑ PANCREATIC CONDITIONS
❑ ADRENAL DYSFUNCTION ❑ HOT/COLD INTOLERANCE ❑ POLYURIA ❑ ABNORMALLY THIRSTY ❑ PURPLE STRIAE ❑ OTHER?

SKIN & BLOOD HEALTH: ❑ PSORIASIS ❑ SKIN CANCER ❑ NEW RASHES ❑ HYPER/HYPO PIGMENTATION ❑ EXCESSIVE ACNE ❑ ECZEMA
❑ EASY BRUISING ❑ BLEEDING GUMS ❑ BLOOD WITH STOOLS ❑ EXCESSIVE HAIR LOSS ❑ OTHER?

FOR WOMEN ONLY: ARE YOU **PREGNANT**? ❑ NO ❑ YES WHEN IS YOUR **DUE DATE**?____/______/______ ARE YOU NURSING? ❑ NO ❑ YES

ARE YOU **TAKING BIRTH CONTROL**? ❑ NO ❑ YES **DO YOU:** EXPERIENCE PAINFUL PERIODS? ❑ NO ❑ YES
HAVE IRREGULAR CYCLES? ❑ NO ❑ YES
HAVE BREAST IMPLANTS? ❑ NO ❑ YES

PERSONAL PAST MEDICAL HISTORY

INSTRUCTIONS: *Please check each of the surgeries, medications, illnesses, or accidents that **relate to you**.*

SURGICAL HISTORY: ❑ LOW BACK FUSION ❑ NECK FUSION ❑ DISCECTOMY ❑ HIP REPLACEMENT L/R ❑ SHOULDER REPAIR/REPLACEMENT L/R
❑ KNEE REPAIR/REPLACEMENT L/R ❑ CARDIAC BYPASS ❑ APPENDIX ❑ GALL BLADDER ❑ PACEMAKER/DEFIBRILLATOR IMPLANTATION
❑ GASTRIC BYPASS ❑ HYSTERECTOMY ❑ THYROIDECTOMY ❑ IMPLANTS ❑ C-SECTION ❑ OTHER?_______________

ILLNESSES: ❑ CANCER ❑ DIABETES ❑ HEART DISEASE ❑ ARTHRITIS ❑ STROKE ❑ CONGENITAL ANOMALY ❑ MULTIPLE SCLEROSIS
❑ BLEEDING DISORDERS ❑ DEPRESSION ❑ EMPHYSEMA ❑ EPILEPSY ❑ HEPATITIS ❑ OSTEOPOROSIS ❑ PARKINSON'S ❑ LYME DISEASE
❑ LUPUS ❑ OTHER?_______________

ACCIDENTS: ❑ SINGLE MOTOR VEHICLE ACCIDENT ❑ MULTIPLE MOTOR VEHICLE ACCIDENTS ❑ WORK RELATED INJURY ❑ BOATING ACCIDENT
❑ MOTORCYCLE ACCIDENT ❑ OTHER? EXPLAIN:_______________

FAMILY AND SOCIAL HISTORY

INSTRUCTIONS: *Please indicate the illnesses **present in your immediate family**, then tell us a little bit more about yourself.*

ILLNESSES IN YOUR IMMEDIATE FAMILY: ❑ CANCER ❑ DIABETES ❑ HEART DISEASE ❑ ARTHRITIS ❑ STROKE ❑ CONGENITAL ANOMALY
❑ MULTIPLE SCLEROSIS ❑ BLEEDING DISORDERS ❑ DEPRESSION ❑ EMPHYSEMA ❑ EPILEPSY ❑ HEPATITIS ❑ OSTEOPOROSIS
❑ PARKINSON'S ❑ LYME DISEASE ❑ LUPUS ❑ OTHER?

WORK HABITS: ❑ RETIRED ❑ FULL TIME ❑ PART TIME ❑ UNEMPLOYED ❑ DISABLED ❑ STUDENT ❑ HOMEMAKER
❑ MOST SITTING ❑ MOSTLY STANDING ❑ MOSTLY WALKING ❑ LIGHT LABOR ❑ MODERATE LABOR ❑ HEAVY LABOR ❑ SEDENTARY

SOCIAL HABITS:

ALCOHOL CONSUMPTION: ❑ NONE ❑ LIGHT ❑ MODERATE ❑ HEAVY ❑ ALCOHOLIC ❑ RECOVERING ALCOHOLIC
TOBACCO: ❑ NEVER ❑ LIGHT ❑ MODERATE ❑ HEAVY ❑ EVERY DAY ❑ OCCASIONAL ❑ FORMER
CAFFEINE: ❑ 1 CUP CAFFEINE IN AM ❑ 2-4 CUPS CAFFEINE/DAY ❑ 5 OR MORE CUPS CAFFEINE/DAY
RECREATIONAL DRUGS: ❑ NEVER ❑ LIGHT ❑ MODERATE ❑ HEAVY ❑ DRUG ADDICTED ❑ RECOVERING ADDICT

EXERCISE HABITS: ❑ NONE ❑ ALMOST NOTHING ❑ DAILY ❑ EVERY OTHER DAY ❑ FEW TIMES A WEEK ❑ ONCE A WEEK
WHAT TYPES OF EXERCISE DO YOU PREFER?_______________

DIET AND NUTRITION: ❑ TAKE DAILY SUPPLEMENTS ❑ DIABETIC ❑ GLUTEN/FOOD SENSITIVITIES ❑ VEGAN ❑ VEGETARIAN
❑ IDEAL PROTEIN ❑ ATKINS ❑ SOUTH BEACH DIET ❑ JENNY CRAIG ❑ PALEO ❑ WEIGHT WATCHERS ❑ OTHER?_______________

CHIROPRATIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

HAVE YOU SEEN OR HEARD OF OUR OFFICE BECAUSE OF (ALL THAT APPLY):
❑ NEWSPAPER ❑ PROMOTER ❑ SIGN ❑ YELLOW PAGES ❑ COMMUNITY EVENT ❑ RADIO ❑ FACEBOOK

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE?
❑ YES ❑ NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR'S NAME:

APPROXIMATE DATE OF LAST VISIT:

QUADRUPLE VISUAL ANALOGUE SCALE

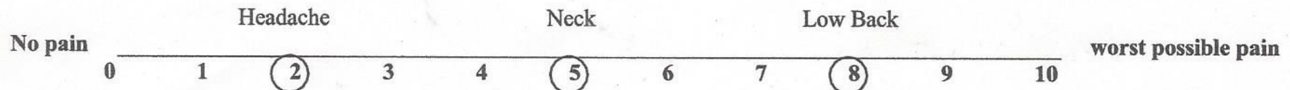
Patient Name ______________________________ Date ________________

Please read carefully:

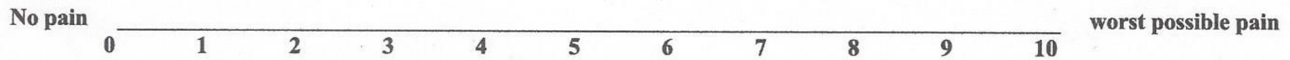
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

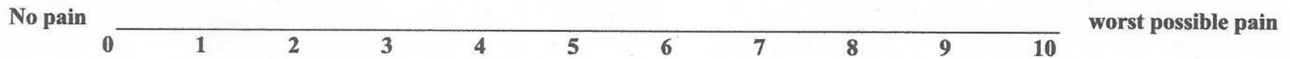
Example:



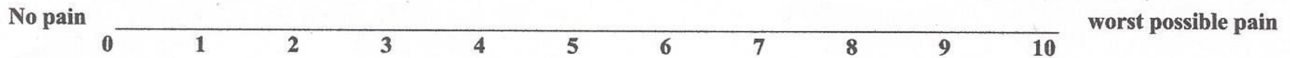
1 – What is your pain RIGHT NOW?



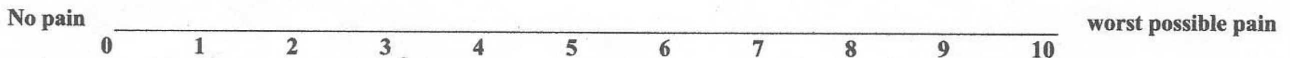
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



OTHER COMMENTS:

____

____

____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

IMPORTANT INSURANCE INFORMATION – PAYMENT POLICY

Welcome to our office. Ada Chiropractic Clinic will prepare any necessary reports and forms to assist you in making collections from your insurance company. Any amount authorized to be paid directly to Ada Chiropractic Clinic will be credited to your account upon receipt. You must CLEARLY UNDERSTAND and agree, however, that all services rendered to you are charged directly to you and that you are personally responsible for payment.

Most health insurance covers Chiropractic care. We at Ada Chiropractic Clinic do not know if your policy covers Chiropractic Care and we make no representation that yours does. We encourage each patient to fully understand their insurance coverage and suggest that you contact your insurance carrier with regards to your specific policy.

Because of the variance from one policy to another we have established the following protocol for our insurance patients:

1. Deductible must be paid.
2. Co-Payments should be paid on a daily or weekly basis.
3. Co-Insurance and non-covered services should be paid monthly.
4. Account balances beyond 90 days will be charged a 1.5% monthly service charge.
5. Insurance companies do not pay for vitamins, supports or supplies. These items are to be paid at the time of purchase.
6. Should arrangements other than the terms of this agreement need to be made please speak with someone in the billing office during your next visit or contact them by phone at 218-784-2330.

MEDICAL ASSISTANCE/MN CARE PROGRAMS:
If at any time during my course of treatment I am ineligible for benefits, I understand that I will be held responsible for services received.

WORK-COMP, AUTO ACCIDENTS OR PERSONAL INJURIES:
In the event that the third party fails to pay for any part or all of these charges, I agree that my liability for this bill is not waived and that I will be held personally responsible.

WE LOOK FORWARD RO CARING FOR YOU AND YOUR FAMILY IN OUR OFFICE!

PATIENT SIGNATURE:____ DATE:____________

CONSENT FOR TREATMENT

I, the undersigned, hereby authorize Dr. JASON MENGE and whomever he/she may designate as his/her assistant (s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.
I also certify that no guarantee or assurance has been made to the results that may be obtained.
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. Collection cost, filing and attorney's fees will be added to cash balances exceeding 90 days old. **I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my insurance claim(s) and also to certify that all insurance information given to this clinic is correct and complete.

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize the ___________________________________ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to Ada Chiropractic Clinic, the entirety of benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said professional charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

ATTORNEY REPRESENTATION AND PROTECTION OF BALANCE

I, the undersigned patient am directing my Attorney, ____________________________, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance, I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment, but will require me to make payment on a current status.

Notice Of Privacy Policy

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- **You may request restrictions on your disclosures.**
- **You may inspect and receive copies of your records within 30 days with a request.**
- **You may request to view changes to your records.**
- **In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and it's staff.**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.**
- **Obtain payment from third party payers**
- **Conduct normal healthcare operations such as quality assessments and physician's certifications.**

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient Name (Print):____

Relationship to Patient (if not filling out for self)**:** ____

Signature:____ **Date:**_________________________