Oak Springs Chiropractic:
A Creating Wellness
Center

1015 Helmo Ave N. Oakdale, MN 55128

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: _____ Phone #: _____

How did you hear about us?: _____

Name of Medical Doctor(s): _____

- authorize the doctor and his staff to render care as deemed appropriate for me and/or my child.
- I authorize Oak Springs Chiropractic to release and/or request records to and from other providers as may be necessary.
- I authorize the use of my name, images, voice and testimony to be used in photographic, audio, video or written form.
- I understand I am responsible for all bill 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 Insurance

_____ _____

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 ❑ Aching ❑ Stabbing ❑ Numb/Tingle ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in the evening ❑ Pain radiates to _____
2. _____ **How long has this been an issue?** _____
   Is it: ❑ Dull ❑ Sharp ❑ Aching ❑ Stabbing ❑ Numb/Tingle ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in the evening ❑ Pain radiates to _____
3. _____ **How long has this been an issue?** _____
   Is it: ❑ Dull ❑ Sharp ❑ Aching ❑ Stabbing ❑ Numb/Tingle ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in the evening ❑ Pain radiates to _____
4. _____ **How long has this been an issue?** _____
   Is it: ❑ Dull ❑ Sharp ❑ Aching ❑ Stabbing ❑ Numb/Tingle ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse
   ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in the 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 doctors have you seen for this?** _____
   _____
9. **Type of treatment:** _____
10. **Results:** _____

Notes: _____

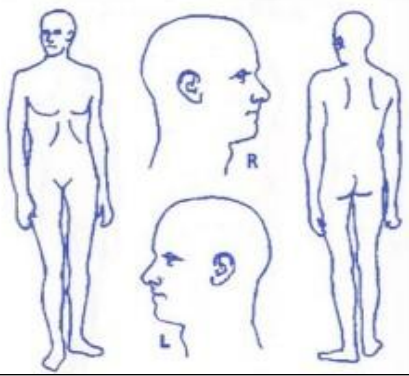
_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark all areas of concern.



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GENERAL HEALTH HISTORY

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Patient Name: _____ **Mark the conditions that apply to you:**

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Brusing
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Asthma / Allergies	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner Use
❑	❑	Cold Hands or Feet	❑	❑	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 you are 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

1. **List any past auto collisions:** _____ **Was any care received?** _____
2. **List any past work injuries:** _____ **Was any care received?** _____
3. **List any past sport, recreational or home injuries:** _____
   _____
4. **Please describe any past conditions and treatments received:** _____
   _____
5. **Please list any past hospitalizations and surgeries:** _____
   _____

Family History

Father's Side: ❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Stroke ❑ Heavy Medication Use ❑ Arthritis ❑ Other _____

Mother's Side: ❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Stroke ❑ Heavy Medication Use ❑ Arthritis ❑ Other _____

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

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Paying for your care is easy here!

Mark and initial which one is you:

☐ **No Insurance:**

- Easy! Our Care Plans and simple payment arrangements have
- helped over 3500 people and will work great for you too!

Initial_____

☐ **Health Insurance:**

- These days, insurance pays very little if anything for natural drugless care to get you healthy. So, we make it easy!
- We will verify any benefits you may have and send your claims in to your insurance for you.
- If they pay anything after your deductible is met, we will accept payment directly from them.
- You are responsible for any deductible, co-insurance, co-pays and unpaid visits.
- Of course you can use your HSA, HRA and Flex dollars here!
- For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.

Initial_____

☐ **Auto Injury:**

- Auto related injuries are covered 100% in MN. Even if you were at fault or were a passenger. You can get the care you need, and it costs you $0. Great for you!
- All we need is your claim number, insurance, and attorney info.

Initial_____

☐ **Work Injury**:

- Work injuries are covered 100% for up to 12 weeks of care.
- All we need is your claim number and Work Comp ins. info.

Initial_____

☐ **Medicare:**

- Regardless of your condition, Medicare pays for up to a maximum of 12 weeks of care. They have very strict rules and limitations.
- After this you will receive a significant Medicare discount. We simply need a copy of your Medicare card.
- Medicare supplements normally don't pay anything.

Initial_____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

- **Adjustment:** The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
- **Health:** The state of optimal physical, mental and social wellbeing, not merely the absence of disease or infirmity.
- **Vertebral Subluxation:** A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____being the parent or legal guardian of

_____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Patient's Acknowledgement of Receipt of Notice of Privacy Practices, State of MN HIPAA Law Attachment and Access to Health Records Notice:

I _____, acknowledge that I have read and was given a copy
(Print Patient's Name)

of Oak Springs Chiropractic and Wellness LLC.'s, Notice of Privacy Practices, State of MN HIPAA Law Attachment and Access to Health Records Notice and fully understood same and have had all my questions answered to my satisfaction.

_____, _____
Patient's Signature Date

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INFORMED CONSENT TO CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

I certify that I'm the patient or legal guardian listed below. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Name: _____

Signature: _____ **Date:** _____

Parent or Guardian: _____