

Patient Health History
GREAT LAKES CHIROPRACTIC

12000 Elm Creek Blvd. Ste L70
Maple Grove, MN 55369
Phone 763-420-4635 Fax 763-390-1381

Date: _____ Name: _____ Email: _____

Social Security#: _____ Age: _____ Birth Date: _____ Marital Status: M S W D

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Occupation: _____ Employer/City: _____/_____

Name of Spouse/Guardian: _____ Spouse's Occupation _____

Spouse's Employer/City: _____/_____ Spouse Work Phone: _____

Number of Children: _____ Names and Ages of Children: _____

Name of Nearest Relative: _____ Phone: _____

How were you referred to our office: _____

Family Medical Doctor: _____

Have you had any previous chiropractic care? Yes or No If yes, when was your last adjustment: _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint: Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto _____ Work _____ Other _____

Have you ever had the same or a similar condition? Yes or No If yes, when and describe: _____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

- | | | |
|---|--|--|
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Cold/Tingling Extremities |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Clicking Jaw | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> General Stiffness | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Sleep |

FEMALES ONLY: When was your last period? _____ Are you pregnant? ___ Yes ___ No ___ Not Sure
Due Date: _____

PAST MEDICAL HISTORY:

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Broken or Fractured Bones | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gall Bladder |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Strokes | <input type="checkbox"/> Coughing Blood | |
| <input type="checkbox"/> A Congenital Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> High/Low Blood Pressure | | |

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, hospitalizations, injuries, falls, auto accidents or surgeries? Please include dates: _____

Have you been treated for any health condition by a physician in the last year? Yes or No

If yes, describe: _____

MEDICATIONS:

What medications or drugs are you taking? _____

List any nutritional supplements you are taking (vitamins, herbs, naturopathic remedies, etc.): _____

Do you have allergies of any kind? Yes or No If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be: _____

FAMILY DISEASES (check if applicable and indicate whether family member is **F**ather, **M**other, **S**ister, **B**rother):

- | | | |
|--------------------|----------------------|----------------------|
| Tuberculosis _____ | Cancer _____ | Mental Illness _____ |
| Diabetes _____ | Asthma _____ | Heart Disease _____ |
| Stroke _____ | Kidney Disease _____ | Lung Disease _____ |
| Arthritis _____ | Liver Disease _____ | Other _____ |

SOCIAL HISTORY:

Do you drink alcoholic beverages? ___ If so, how much per week? _____

Do you use any tobacco products? _____ Do you smoke? ___ If so, packs per day: _____

Do you consume caffeine? ___ If so, how much per day: _____

Do you exercise? _____ If yes, what is the frequency and type of exercise? _____

What are your hobbies? _____

What percentage of time during the day (at home or at your job away from home) do you spend:

lifting _____ sitting _____ bending _____ working at a computer _____

The patient understands and agrees to allow Great Lakes Chiropractic to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____

Date: _____

Guardian's Signature Authorizing Care: _____

Date: _____



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Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Relief Care

Relief Care is the care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective Care is the care necessary to get rid of your symptoms or pain, while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Care

Corrective Care

Check here if you want the Doctor to select the type of care appropriate for your condition

Insurance Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for the examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this Office. The patient also agrees he/she is responsible for all bills incurred in this Office.

Patient Signature _____ Date _____

Consent to Treat a Minor _____ Date _____

Guardian or Spouse's
Signature of Authorizing Care _____ Date _____

Guardian's Social Security Number (required to treat a minor) _____

Dr. Phillip J. Detlefsen
Chiropractor

Dr. Kimberly Martin
Chiropractor



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Standard Consent Form

Any procedure intended to help may also do harm. While chiropractic procedures done in this office are usually considered remarkably safe and effective, please understand there are occasional and rare complications which have been documented. While the chances of experiencing these complications are extremely small, it is the practice of this office to fully inform and educate all of our patients about them. Cervical manipulations have rarely caused injuries to the small blood vessels that go to and from the upper neck to the brain. The risk of this occurring is thought to be one in three million to one in fourteen million, according to several studies. These other complications include but are not limited to:

pain	burns	swelling	sensory changes
soft tissue injury	bruising	bleeding	stroke(CVA)
discoloration	fracture	dizziness	inflammation
disc injury	nausea	weakness	soreness

By signing this I understand that there is no guarantee or warranty of a specific cure or result. I understand that I can request specific additional information from the doctor regarding treatment risk. Given this information, I consent to care.

PATIENT SIGNATURE: _____ DATE: _____

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Chiropractor

Dr. Kimberly Martin
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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 doctor and patient to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra 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 or condition other than vertebral subluxation. However, if during the course of a Chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advise, diagnosis, or treatment for these findings, we will recommend that you seek the services of a health care provider who specializes in that area.

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 a major interference to the expression of the body's natural ability toward self healing. Our only method is specific adjusting to correct vertebral subluxations.

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

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on the basis

(Signature)

(Date)

Dr. Phillip J. Detlefsen
Chiropractor

Dr. Kimberly Martin
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RECORDS RELEASE

I authorize the release of my records/x-rays or copies of such to the office of GREAT LAKES CHIROPRACTIC, 12000 Elm Creek Blvd. Suite L70, Maple Grove, MN 55369.

This records release is valid for one year from the date of my signature.

PRINTED NAME OF PATIENT: _____

NAME OF PARENT OR GUARDIAN: _____

PATIENT SIGNATURE: _____ DATE: _____

PATIENT SS#: _____ PATIENT DATE OF BIRTH: _____