Art District Chiropractic
208 13th Ave NE. Minneapolis
P: 612-741-2736 F: 612-252-0379

PATIENT INFORMATION
Name:____
Address:____
City:________________________________Zip Code______________
Home Phone:____________________________Work Phone:__________________________
Cell/Other________________________________Preferred #: ☐ home ☐ work ☐ cell
E-mail Address:__________________________ Birthdate:___________Age:_____ Gender: ☐ M ☐ F
Occupation:________________________________Employer:___________________________________
How were you referred to Art District Chiropractic?
☐ Family Member ☐ Friend ☐ Doctor ☐ Other:____
Please give us the name of the family member, friend, or doctor that referred you__________________
In event of an Emergency
Name:____________________________________Relationship to Patient:________________________
Home phone:____________________cell:_____________________work:_________________________
INSURANCE INFORMATION
Auto Accident____________________Work Injury___________________Medicare________________
Medical Assistance________________Private Insurance_______________Cash____________________
Primary Insurance Company____
ID #______________________Claim #_________________________Phone #_____________________
Address____
Date of Accident/Injury________________________________Attorney__________________________

I hereby state that the information on this form is true and correct. I authorize Dr. ____________ to examine, take x-rays and treat for the care and management of my condition in accordance with the state statutes. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr.___________ will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid, be paid directly to Art District Chiropractic, LLC which will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I hereby authorize the release of my health evaluation, examination, prognosis, and treatment records to my employer, attorney, or insurance company. Please notify office staff if you have any questions or concerns regarding this Office Policy Statement. If you are in agreement with this statement please sign and date below.

Patient Signature: ____ Date: ____________________

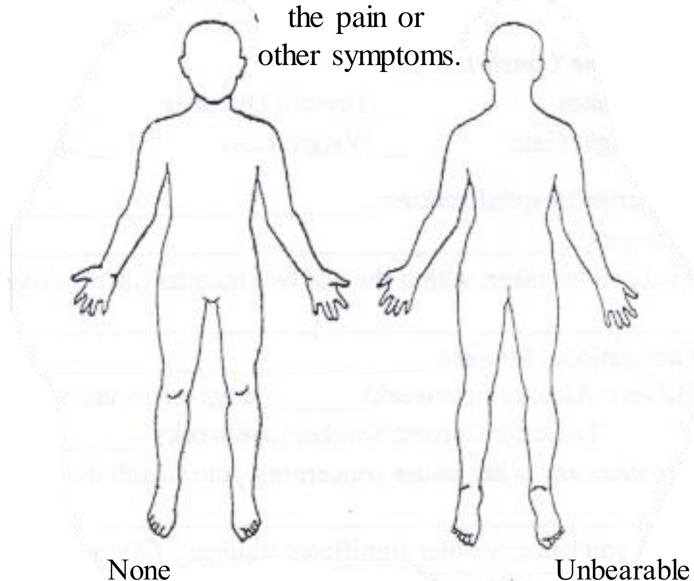
Briefly describe your current symptoms?____
____

When did your symptoms start? ____
____

How did this begin?____
____

Is your current injury/condition related to an auto/work accident? Y N
If yes, what is the date of the accident? _______

Please mark the location where you have the pain or other symptoms.



None Unbearable

Rate the severity of your pain in the last 24 hours

0 1 2 3 4 5 6 7 8 9 10

In the last week

0 1 2 3 4 5 6 7 8 9 10

Please describe your symptom(s).

☐Sharp ☐Dull Ache ☐ Numb ☐Shooting
☐Burning ☐Tingling ☐Other___________

Since your symptom(s) began, are they….

☐ Increasing ☐ Decreasing ☐ Not changing

How often do you experience your symptom(s)?

☐ Constantly (76-100%) ☐ Frequently (51-75%)
☐ Occasionally (26-50%) ☐Intermittently (0-25%)

If anything, what makes this better? _________________
____

If anything, what makes this worse?_________________
____

How much have your symptoms interfered with your usual daily activities? (outside the home & housework)

☐Not at all ☐A little bit ☐Moderately
☐Quite a bit ☐Extremely

How is your condition changing, since care began at this facility?

☐N/A – this is the initial visit ☐Much Worse ☐Worse ☐A little worse ☐No change ☐ A little better ☐Better ☐Much Better

In general, would you say your overall health right now is…

☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

Please list any other health care providers consulted for this condition.
____

Past Chiropractic Care? **☐Yes** **☐No** Dr. Name/Location: ________________________________

Women: Are you or is there a possibility that you may be pregnant?______________________________________
If yes, what is your due date? ___________________

For Office use only:
Dx: codes: ________ ________ ________ ________

Please indicate if you have had or presently have any of the following conditions:

Past	Present		Past	Present		Past	Present	
○	○	Neck Pain	○	○	Nausea/Vomiting	○	○	Dizziness
○	○	Upper Back Pain	○	○	Black/Bloody Stools	○	○	Headaches
○	○	Mid Back Pain	○	○	Gallbladder Problems	○	○	Stroke
○	○	Low Back Pain	○	○	Liver Problems	○	○	Seizures
○	○	Osteoporosis	○	○	Constipation	○	○	Numbness
○	○	Arthritis	○	○	Diarrhea	○	○	Muscular Incoordination
○	○	Joint Stiffness	○	○	Ulcers	○	○	Brain Aneurysm
○	○	Muscle Weakness	○	○	Abdominal Pain			
○	○	Jaw Pain	○	○	Loss of Bladder Control	○	○	Hepatitis
○	○	Rheumatoid Arthritis	○	○	Kidney Disease	○	○	Blood Clots
			○	○	Kidney Stone	○	○	Easy Bruising
○	○	Heart Disease/Attack	○	○	Burning/Painful Urination	○	○	Easy Bleeding
○	○	Pacemaker	○	○	Frequent Urination	○	○	Cancer
○	○	High Blood Pressure	○	○	Blood in Urine			
○	○	Irregular Heartbeat	○	○	Prostate Problems	○	○	Depression
○	○	Chest Pains				○	○	HIV/AIDS
			○	○	Eye Pain	○	○	Diabetes
○	○	Asthma	○	○	Visual Disturbances	○	○	Tumor
○	○	Difficulty Breathing	○	○	Other Vision Issues: ____________________	○	○	Thyroid Disorder
○	○	Shortness of Breath			**Other Health Conditions**	○	○	Abnormal Weight Gain/Loss
○	○	Allergies	○	○		○	○	Difficulty Sleeping
○	○	Emphysema	○	○		○	○	Menstrual Problems
○	○	Chronic Sinusitis	○	○		○	○	Pregnancy
○	○	General Fatigue				○	○	ADD/ADHD

Indicate if an *immediate* family member has had any of the following:
___Rheumatoid Arthritis ___Heart Problems ___Diabetes ___Cancer ___Lupus ___Stroke ___Other______

Surgeries/Hospitalizations/Joint Replacements: ____

Serious Illness or injury/Broken Bones:____

Allergies:____

Medications taken within the last two months (include over the counter and vitamins): ______________________

____

Habits: Caffeine (use/day) _____ Alcohol (use/week) _____ Drugs (type, use/week)________

Tobacco: Current Smoker (use/week): ____ Former Smoker, quite date:______ Never Smoked ____

Are there any other issues concerning your health that you would like the doctor to be aware of? ___________

____

Have you had any other significant traumas? (Auto Accidents, falls, etc): ________________________________

____

_________ Patient Initial