Mankato Chiropractic & Mankato's Healing Touch

Mankato Chiropractic Center 31 Navaho Ave, Mankato, MN 56001
507-345-4035

PLEASE PRINT ALL INFORMATION **DATE:** ______________ Dr. _______________

NAME: ____
(First Name) (MI) (Last Name)

ADDRESS: ____

CITY: _________________________________ **STATE:** _______ **ZIP:** ____________

HOME PHONE: (____)_________________ **CELL PHONE:**(____)_________________

BIRTH DATE: ___/___/___ **AGE:** _____ **SEX:** M or F **MARTIAL STATUS:** M S W D

SOCIAL SECURITY #: ______-_____-______ **E-mail :** _____________________________

This information will be kept confidential. Check one in each section.

ETHNICITY: __ Hispanic/or Latino __ Not Hispanic or Latino ___ Decline

RACE: ___White ___Asian ___Black/African American ___Hispanic/Latino ___American Indian/Alaska Native __ Native Hawaiian or other Pacific Islander ___Other List_________ ____Decline

The above information is required as a result of the implementation of electronic health record based on Medicare/Medicaid guidelines.

OCCUPATION: ______________________**EMPLOYER:** _____________________________

ADDRESS: ____

CITY: _________________________________ STATE: ______ ZIP: __________

WORK PHONE: (____)_______________ May we contact you at this number?____yes ____no

SPOUSE'S/PARENT'S NAME: _____________________ Birth Date: _____/_____/_____

NEXT OF KIN (Not living with you): this section needs to be completed if you are a full time student

NAME: ____________________________________

ADDRESS: ____

CITY: _________________________________ STATE: _______ ZIP: ___________

HOME PHONE: (____)____________________

WORK PHONE: (____)____________________

REFERRED BY: ______________________________

PURPOSE OF THIS APPOINTMENT: _____________________________________

OTHER DOCTORS SEEN FOR THIS CONDITION: ____________________________

DATE OF LAST PHYSICAL EXAMINATION: ________________

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION BY A PHYSICIAN IN THE LAST YEAR? YES or NO Date: ____________________

REASON: ____

OVER - ADDITIONAL INFORMATION ON BACK PAGE....

FINANCIALLY RESPONSIBLE PARTY:

NAME: ______________________________

RELATIONSHIP TO PATIENT: ______________________

ADDRESS: ____

CITY: ___________________________ STATE: _____ ZIP: _________

SOCIAL SECURITY #: _______-____-________

HOME PHONE: (____)_________________

WORK PHONE: (____)_________________

CO-PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT!
(Unless other arrangements are made)

The following information is necessary to submit claims to your insurance. Failure to give Mankato Chiropractic center the complete information below will activate patient responsibility for services rendered.

Are you Insured? YES or NO Company: ________________________

Name of Insured:____________________

Your relationship to insured:____________ (Spouse, mother, father, child)

Insured's Date of Birth:___/___/_____(cannot process claims without insured's date of birth)

In consideration of services provided, I am agreeing to pay for services provided to me, to my spouse, and to my minor children. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Mankato Chiropractic Center files insurance claims as a courtesy to their patients. You are strongly encouraged to contact your insurance company or legal counsel to determine the likelihood of reimbursement for chiropractic services. We will not become involved in disputes between the patient and their insurance company regarding deductible, co-payment, covered charges, secondary insurance, usual and customary charges, etc. Do not assume under any circumstances that you are relieved of any financial obligations. Furthermore, I understand that, if I wish, Mankato Chiropractic Center 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 Mankato Chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me, to my spouse, and to my minor children are charged directly to us and that we are personally responsible for timely payment. Failure of timely payment on my part of any charges billed to me may result in collection action.

Patient's Signature: _____________________________________

Parent's or Guardian's Signature: ___________________________

Mankato Chiropractic Center Patient Health Questionnaire

Mankato Chiropractic & Mankato's Healing Touch

Name:______________________________ Date:____________

Describe your symptoms in detail:______________________________

____

____

When did these symptoms start?______________________________

What caused your symptoms to begin?______________________________

How often do experience symptoms?

- ☐ Constantly (100-76% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (1-25% of the day)
- ☐ Sporadically (symptoms are not daily)

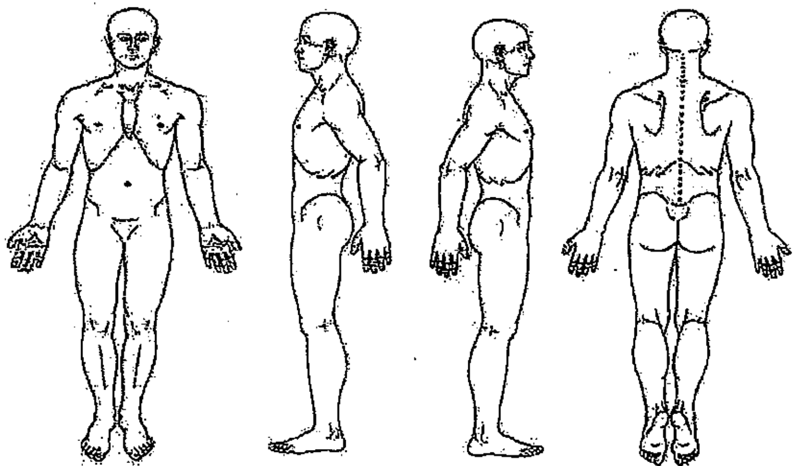
How are your symptoms progressing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Worsening

What best describes the nature of your pain?

☐ Sharp	☐ Burning	☐ Achy
☐ Stabbing	☐ Tingling	☐ Stiffness
☐ Shooting	☐ Spasming	☐ Tightness
☐ Dull pain	☐ Throbbing	☐ Pinching

Mark on the picture below where you have pain or other symptoms



Grade your pain level TODAY: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Grade the Average intensity of your pain the past week: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

How much does your pain interfere with your daily activities? (work, exercise, socially, activities of daily living, etc.)

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

Have you been treated for this episode? ☐ Yes ☐ No When?____________

If yes, by whom? ☐ MD ☐ Chiropractor ☐ Massage Therapist ☐ PT ☐ Other____________

What treatment did you receive? ______________________________

Have you been treated for a similar problem in the past? ☐ Yes ☐ No When?____________

If yes, by whom? ☐ MD ☐ Chiropractor ☐ Osteopath ☐ Physical Therapist ☐ Other____________

What treatment did you receive? ______________________________

What has helped in the past?______________________________

Your general physical activity: ☐ No regular exercise ☐ Light exercise ☐ Moderate exercise ☐ Strenuous exercise

Your general stress level: ☐ Little or no stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed

Occupation: ____________________ ☐ Full time ☐ Part time

Physical activity at work:

☐ Sitting more than 50% of the day ☐ Light manual labor ☐ Manual labor ☐ Heavy labor ☐ Repeated motion

Patient Signature______________________________ Date:____________

See other side for more patient health information ➡

Mankato Chiropractic & Mankato's Healing Touch

Mankato Chiropractic Center Patient Health Questionnaire Page 2

Name:______________________________ Date:__________________

CHECK ONE:

- ☐ Current every day smoker
- ☐ Current occasional smoker
- ☐ Former smoker
- ☐ Never a smoker

Please Indicate:

Past	Present	
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Lower Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/ Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	TMJ/ Jaw Pain
☐	☐	Hip/ Upper Leg Pain
☐	☐	Knee Pain
☐	☐	Ankle/ Foot Pain
☐	☐	Fibromyalgia
☐	☐	Joint Swelling
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Restless Leg Syndrome
☐	☐	Chest Pain
☐	☐	High Blood Pressure
☐	☐	Difficulty Breathing

Past	Present	
☐	☐	Dizziness
☐	☐	Loss of Conciousness
☐	☐	Racing Heart
☐	☐	General Fatigue
☐	☐	Loss of Coordination
☐	☐	Rapid Weight Change
☐	☐	Bruise Easily
☐	☐	Anemia
☐	☐	Depression
☐	☐	Night Sweats
☐	☐	Insomnia
☐	☐	Alcohol Dependancy
☐	☐	Drug Dependence
☐	☐	Kidney Dysfunction
☐	☐	Kidney Stones
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Heartburn
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Nausea/ Vommiting
☐	☐	Difficulty Swallowing
☐	☐	Blood in Stool
☐	☐	Abdominal Pain
☐	☐	Loss of Appetite

Past	Present	
☐	☐	Cancer
☐	☐	Asthma
☐	☐	Chronic Sinusitis
☐	☐	Lupus
☐	☐	Diabetes
☐	☐	HIV/ AIDS
☐	☐	Hepatitis
☐	☐	Epilepsy
☐	☐	Eczema
☐	☐	Psoriasis
☐	☐	Osteoperosis
☐	☐	Multiple Sclerosis
☐	☐	Pregnancy
☐	☐	Pace Maker Implant
☐	☐	Car accident
☐	☐	Trauma

Immediate Family History of:

- ☐ Cancer
- ☐ Rheumatoid Arthritis
- ☐ Heart Problems
- ☐ Diabetes
- ☐ Lupus
- ☐ Parkinsons
- ☐ Dementia

List all prescription medications and supplements you are currently taking (If you have a list the staff can make a copy)

____

____

____

____

List all allergies to medications:______________________________________

List all surgical procedures you have had performed:______________________

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