



PLEASE PRINT ALL INFORMATION DATE: _____ Dr. _____

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

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____ CELL PHONE:(____) _____

BIRTH DATE: ____/____/____ AGE: _____ MARTIAL STATUS: M S W D

SOCIAL SECURITY# _____ - _____ - _____ EMAIL: _____

This information is 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 records based on Medicare/Medicaid guidelines.

OCCUPATION: _____ EMPLOYER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: (____) _____ May we contact you at this number? Yes No

FINANCIALLY RESPONSIBLE PARTY:

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

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.

Insurance 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.

Signatures/Patient: _____ Parent or Guardian : _____

Mankato Chiropractic Center Patient Health Questionnaire

Name: _____

Date: _____

Describe your symptoms in detail: _____

When did these symptoms start? _____

What caused your symptoms to begin? _____

How often do you 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)

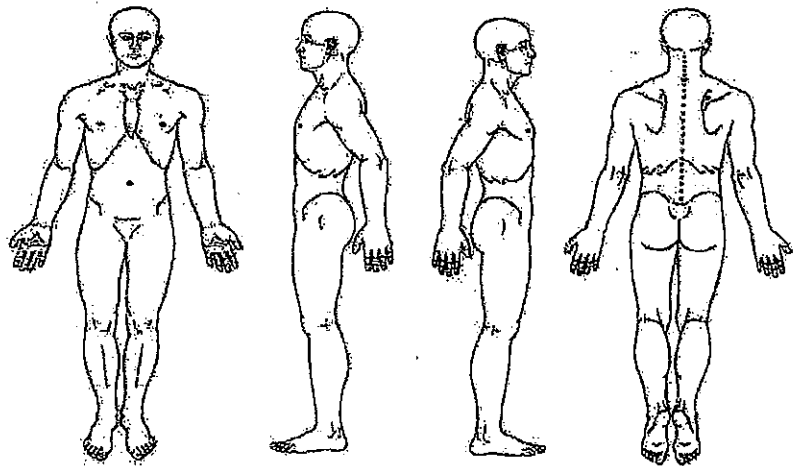
How are your symptoms progressing?

- Getting Better
- Not Changing
- Worsening

What best describes the nature of your pain?

- | | | |
|------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Achy |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Tingling | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Spasming | <input type="checkbox"/> Tightness |
| <input type="checkbox"/> Dull pain | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Pinching |

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



(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Grade your pain level TODAY:

Grade the Average intensity of your pain the past week:

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 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			Past	Present
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Racing Heart	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Coordination	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	HIV/ AIDS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Osteoperosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Dependancy	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug Dependence	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker Implant
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Car accident
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Trauma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/ Vommiting			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Stool			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite			

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: _____
