TYSDAL CHIROPRACTIC

Please fill out this form in detail. The information will be used to assist the doctor in best serving you.
The information is confidential and will only be used for clinical purposes.

Patient Information

Today's Date:_____

Full Name:_____ Preferred Name:_____ Sex: ◉Female ○Male

Address: _____ Apt./Unit Number_____

City:_____ State:_____ Zip Code:_____

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

Email:_____ Birth Date:_____ (Age:_____) SS#: _____

Occupation:_____ Employer:_____

Marital Status: □ Single □ Married □ Other Name of Spouse:_____

Names/Ages of Children Living At Home:_____

Name and Number of Emergency Contact:_____

How were you referred to Tysdal Chiropractic?

□ Family Member □ Friend □ Doctor □ Internet □ Newspaper □ Phone Book □ Other_____

Please give us the name of the family member, friend or doctor that referred you:_____

Insurance Information

Insurance Company:_____ Policy Number: _____Group Number:_____
Policy Holder's Name:_____ Policy Holder's Birth Date:_____
Policy Holder's Relationship to the Patient: □ Self □ Spouse □ Parent/Guardian □ Other_____

Chiropractic History

Have you been under Chiropractic care before? □ Yes □ No If yes, date of last visit?_____

Was your chiropractic experience positive, negative, neutral?_____

Reason:_____

Current and Past Conditions

*Please indicate if you have or have had any of these conditions

□ Headaches	□ Back Pain	□ Neck Pain	□ Pins/ Needles in Arms/Legs
□ Shoulder Pain	□ Stress	□ Muscle Tension	□ Overall Joint Pain/Stiffness
□ Difficulty Walking/Sitting	□ Difficulty Driving	□ Difficulty Working	□ Difficulty Lifting/Bending
□ Weakness	□ Loss of Balance/Dizziness	□ Fatigue	□ Loss of Coordination
□ Frequent Colds/Flu	□ Ringing in Ears	□ Sinus Problems	□ Diarrhea/Constipation
□ Indigestion	□ Sleeping Problems	□ Allergies	□ Asthma
□ Anxiety	□ Depression	□ Moody/ Irritable	□ Lack of Concentration
□ High Blood Pressure	□ Vision Problems	□ Poor Memory	□ Menopausal Difficulties
□ Fertility Dysfunction	□ Prostate Dysfunction	□ Sexual Dysfunction	□ Menstrual Difficulties

Surgeries:_____

Serious illness or injury:_____

Allergies:_____

Habits: Smoking/Tobacco use? □ Yes □ No Alcohol use? □ Yes □ No If yes, how many drinks per week? _____

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

_____

Occupational Stresses:_____

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…): □ Yes □ No

If Yes, Please Describe: _____

_____

The MAJOR Symptom/Complaint

Major Complaint:_____

Have you had this problem before? □ Yes □ No When did the problem start?_____

How did this problem start? _____

Is the problem related to an auto/work accident? □ Yes □ No

If yes, what is the date of the accident? _____

Please describe your current pain:

□ Sharp □ Dull Ache □ Numb □ Shooting □ Burning □ Tingling

□ Other _____

Since your problem began, is the pain...

□ Increasing □ Decreasing □ Not Changing

How frequently does your pain occur?

□ Constantly □ Frequently □ Occasionally □ Intermittently

What makes your problem better? _____

_____

What makes your problem worse? _____

_____

Please list other health care providers consulted for this condition:

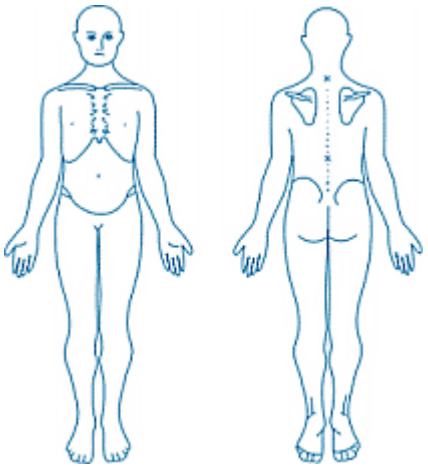
_____

Date of last physical examination: _____

Women: Are you/ is there a possibility that you may be pregnant? □ Yes □ No

If yes, what is the due date? _____

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



*Please rate the severity of your pain

None Unbearable

0 1 2 3 4 5 6 7 8 9 10

THE STATEMENTS MADE ON THESE FORMS ARE ACCURATE TO THE BEST OF MY RECOLLECTION AND I AGREE TO ALLOW THIS OFFICE TO EXAMINE ME FOR EVALUATION.

Signature: _____Date: _____

If under 18, Parent/Guardian Signature: _____Date: _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____ _____

Printed Name of Patient Signature Date

For further information regarding this notice, please contact our Doctor at (218) 998-1099

Chiropractic Informed Consent

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. 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.

Like most health care procedures, a chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with a chiropractic adjustment are extremely rare. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

Symptoms including: dizziness, nausea, and flushing are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care. Other risks associated with chiropractic treatment include rare burns from electrical stimulation. Instruments assisted in soft tissue manipulation may result in temporary soreness or bruising.

When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fractures. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such conditions while you are under care, you will be informed and your treatment plan will be modified to minimize the risk of fractures.

Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there are also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke.

I understand that the treatment I receive at this clinic may be performed by advanced chiropractic interns under the supervision of a licensed Doctor of Chiropractic. I also understand that the practice of chiropractic is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care. I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction. I have made my decision voluntarily and freely.

Printed Name of Patient: _____

Signature: _____ Date: _____

If under 18, Parent/Guardian Signature: _____ Date: _____

Financial Acknowledgement

It is your responsibility for the charges associated with the care received at this facility and to pay any co-pays due at time of service that the insurance company deems is your patient responsibility.

I acknowledge that it is my responsibility to pay any charges and co-pays my insurance policy deems is my responsibility. Initial _____

It is your obligation to inform Tysdal Chiropractic of all your insurance policies. If you have multiple insurance policies, it is essential that the insurance policies are billed correctly the first time.

If you have insurance through a parent or spouse as well as your own insurance policy, we need to be informed of this immediately to ensure we are billing your insurance policies in the correct order.

If the insurance companies are not billed in the correct order the first time, your insurance company may recoup their money paid for the claims and you may be responsible for the full amount of the charges.

I acknowledge that I need to inform Tysdal Chiropractic of all my insurance policies. If I fail to do so, I may be responsible for the full amount of the charges. Initial _____

It is also your obligation to inform Tysdal Chiropractic of any changes to your insurance plans and policies. If we bill old or inactive insurance, it can cause excessive work to find the new insurance and re-bill the claims.

Insurance companies have a small window to submit claims before they can deny for timely filing. Once this window is passed there is little we can do to get the claims paid on your behalf. If your insurance changes and we are unable to get the new insurance information from you, you may be responsible for the full amount of the charges.

I understand it is my obligation to inform Tysdal Chiropractic of any changes to my insurance plans and policies. If my insurance changes and Tysdal Chiropractic is unable to get the new insurance information from me, I may be responsible for the full amount of the charges.

Initial _____

X _____ Date _____