Confidential Patient Health History

GREAT LAKES CHIROPRACTIC

Dr. Phillip Detlefsen
7882 Main Street
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:

___ Low back pain	___ Arm Pain	___ Cold/Tingling Extremities
___ Pain between shoulders	___ Clicking Jaw	___ Numbness
___ Headaches	___ Heartburn	___ Fainting
___ Neck Pain	___ General Stiffness	___ Dizziness
___ Joint Pain/Stiffness	___ Fatigue	___ 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)

__Broken or Fractured Bones	__Osteoarthritis	__Eating Disorder	__HIV Positive
__Circulatory Problems	__Epilepsy	__Alcoholism	__Gall Bladder
__Rheumatoid Arthritis	__Pace Maker	__Drug Addiction	__Ulcers
__Seizures/Convulsions	__Strokes	__Coughing Blood	
__A Congenital Disease	__Cancer	__Depression	
__Excessive Bleeding	__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 HISTORY: (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 ____	Headaches ____
Low back pain ____	Neck Pain ____	Other: _____
Migraines ____	Disc Injuries ____	

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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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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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) _____

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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 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 advice, 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)

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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, 7882 Main Street 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: _____