Date: ___/___/_____

Adult Intake Form (18+)

Name_____ Gender: Male/Female
Preferred Name/Nickname_____ Date of Birth____/_____/_____ Age_____
Address_____City_____State_____Zip_____
Primary Phone _____ Cell/Home/Work Secondary Phone _____ Cell/Home/Work
Email Address _____
Occupation _____ Employer _____
Single / Married / Divorced / Widowed Spouse's/Significant Other Name _____
Number of Children_____ Names, Ages, & Gender _____
_____
Who may we thank for referring you?_____

Emergency Contact

Please list the name of someone we can call in case of emergency – if your primary emergency contact (i.e. spouse or parent/guardian) is already receiving care at True North we will attempt to call them first but would like a secondary in the event we are unable to reach them.

Name of emergency contact: _____
Relationship of contact to you: _____
Phone number(s) for contact: _____
Preferred Hospital: GUNDERSEN MAYO OTHER:_____

List the Main Health Concerns that Brought You into this Office

1) _____ 2) _____ 3) _____ 4) _____
Are there any open auto or workman's compensation claims relating to these main concerns? □ Yes □ No

Please Check Any Issues You Have Had in the Past or Currently Have

___ Neck Pain ___ Scoliosis ___ Hearing Loss ___ High/Low Blood Pressure
___ Shoulder Pain ___ Jaw/TMJ Pain ___ Ringing in the Ears ___ Nausea
___ Arm Pain ___ Headaches/Migraines ___ Dizziness ___ Digestive Issues
___ Back Pain ___ Frequent Colds/Ear Infections ___ Loss of Balance ___ GERD/Gastric Reflux
___ Sciatica ___ Sinus Issues ___ Epilepsy/Seizures ___ Diabetes
___ Hip/Leg Pain ___ Allergies ___ Stroke ___ Kidney Problems
___ Knee Pain ___ ADD/ADHD ___ Tremors ___ Bladder Problems
___ Foot Pain ___ Thyroid Issues ___ Asthma ___ Bedwetting
___ Numb/Tingling in extremities ___ Loss of Energy ___ Sleep Apnea ___ Menstrual Problems
___ Tight/Sore Muscles ___ Sleep Problems ___ Chest Pain ___ Prostate Problems
___ Fibromyalgia ___ Anxiety/Nervousness ___ Difficulty Breathing ___ Sexual Dysfunction
___ Poor Posture ___ Depression ___ Heart Problems ___ Infertility
___ Arthritis/Joint Pain ___ Double/Blurry Vision ___ Heart Attack ___ Cancer

Other conditions/diseases:
_____
_____

Name: _____ Date: ___/___/_____

Health History

List any surgical operations & years:

_____

_____

List any other injuries to your spine, minor or major, that the doctor should know about:

_____

Have you ever fractured or broken a bone? □ Yes □ No

If yes, please describe: _____

Other major traumas (car accidents, sports injuries, slips/falls, etc.):

_____

_____

List all over-the-counter & prescription medications you are on and the reason for each:

_____

_____

_____

Notice of Privacy Practices Acknowledgement (HIPAA)

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____ Date: _____

Name: _____ Date: ___/___/_____

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with Chiropractic care. The types of complications that have been reported secondary to Chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with Chiropractic care occurring at a rate between one instance per one million to one instance per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving Chiropractic care in the Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if Chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with Chiropractic care and give consent to the examination that the Doctor deems necessary and the Chiropractic care, including spinal adjustments, as reported following my assessment.
- I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.

Signature: _____ Date: _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your Chiropractic records. If it is necessary to take x-rays, we must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays on a disc is $15. This fee must be paid in advance. Digital x-rays on a CD will be available within 72 hours of pre-payment during regular practice hours. Please Note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The Doctors of True North Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice. By signing below, you are agreeing to the above terms and conditions.

Signature: _____ Date: _____

FEMALE PRACTICE MEMBERS ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at True North Chiropractic.

Signature: _____ Date: _____