Dr. John Petersen

North Maple Grove Chiropractic

Confidential Patient Information

Welcome to our Chiropractic Office!

Date____________________

Patient's Full Name____

Address____

City – State – Zip code____

Date of Birth_______________ Age_________ Gender: Male Female

Phone: Home_______________Work______________Cell______________

Email address____

Social Security Number____

Height___________ Weight______________ Marital Status_____________

Occupation____

Employer Name____

Employer Address____

Name and Address of Nearest Living Relative not living with you__________

____

Name / Address of your Primary Care Physician________________________

____

It is our policy to send a summary of findings to your doctor, in order to better coordinate your health care.

Who may we thank for referring you to our practice?______________________

9505 Blackoaks Lane North
Maple Grove Minnesota 55311
763-420-4111 fax 763 420-4145

Please list your reason(s) for this visit or your condition(s) in order of importance:	Date you first noticed:	Using a scale in which "0" is none (no pain or symptoms) and "10" is severe pain or symptom(s), **circle** the number that best reflects your condition: ↓ **none . . . . . . to . . . . . . severe** ↓	Please check the box below that best represents how much of the time you feel pain or your symptom(s) for the listed reason:
1 ______	______	0 1 2 3 4 5 6 7 8 9 10	❑0-25% ❑26-50% ❑51-75% ❑76-100%
2 ______	______	0 1 2 3 4 5 6 7 8 9 10	❑0-25% ❑26-50% ❑51-75% ❑76-100%
3 ______	______	0 1 2 3 4 5 6 7 8 9 10	❑0-25% ❑26-50% ❑51-75% ❑76-100%
4 ______	______	0 1 2 3 4 5 6 7 8 9 10	❑0-25% ❑26-50% ❑51-75% ❑76-100%

For each of the reasons or conditions listed above, please mark how it happened:

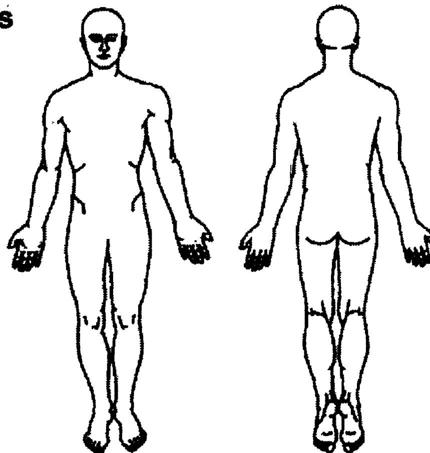
1. ❑Developed over time ❑Illness ❑Injury ❑Auto accident ❑Other ______ ❑ I don't know
2. ❑Developed over time ❑Illness ❑Injury ❑Auto accident ❑Other ______ ❑ I don't know
3. ❑Developed over time ❑Illness ❑Injury ❑Auto accident ❑Other ______ ❑ I don't know
4. ❑Developed over time ❑Illness ❑Injury ❑Auto accident ❑Other ______ ❑ I don't know

For each reason listed above, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER (please describe on line below)		
	better	worse	better	worse	better	worse	better	worse	better	worse	
Reason 1	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	______
Reason 2	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	______
Reason 3	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	______
Reason 4	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	______

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:

+++ Sharp or stabbing
ooo Pins and needles
vvv Dull or aching
/ / / Numbness



Please check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	Normal	Somewhat limited	Severely limited
Lifting	❑	❑	❑
Bending	❑	❑	❑
Standing	❑	❑	❑
Walking	❑	❑	❑
Sitting	❑	❑	❑
Climbing stairs	❑	❑	❑
Running	❑	❑	❑
Resting in bed	❑	❑	❑
Intercourse	❑	❑	❑
Computer work/typing	❑	❑	❑
Normal work	❑	❑	❑
Household activities	❑	❑	❑
Recreational activities	❑	❑	❑
Other (list below)	❑	❑	❑
______	❑	❑	❑

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Chiropractic Patient Information Form

Please continue ...

a. During what time of the day do you feel worse? ______________________________

b. Do you sleep well? ☐ Yes ☐No What are your normal sleeping hours? __________to __________

c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?
☐ No ☐ Yes → For what condition? ______________________________

Name of doctor/provider ______________________ Phone number ______________

d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
☐ No ☐ Yes If yes, please describe each event below:

Event ______________________________ Year ________

Event ______________________________ Year ________

e. Do you exercise? ☐ Yes ☐ No If yes, please describe activity ______________________

How many days a week? _______ How many minutes per session?________

Personal history

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

Pain in body

- ☐ Neck pain with difficulty swallowing
- ☐ Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck
- ☐ Leg pain that worsens with exercise but is relieved by resting
- ☐ Loss of feeling in inner thighs
- ☐ Back pain with urinary problems

Types of pain

- ☐ Severe pain interrupts sleep
- ☐ Constant pain that doesn't improve by changing positions or lying down

Current conditions

- ☐ Unable to balance when walking
- ☐ Recent unexplained weight loss
- ☐ Recent progressive muscle weakness or shaking
- ☐ Recent or current fever over 102°F
- ☐ Loss of bowel or bladder control
- ☐ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ☐ Recent major accident such as a fall from height, whiplash or blow to the head
- ☐ Memory loss after injury

Previously diagnosed condition/ medical history

- ☐ Congenital bone or joint disorder
- ☐ Rheumatoid arthritis
- ☐ Severe degenerative arthritis
- ☐ History of compression fracture
- ☐ History of heart attack
- ☐ History of stroke or aneurysm
- ☐ Past history of cancer or currently diagnosed with cancer
- ☐ Diabetes with cold, burning or numb feet
- ☐ Gout
- ☐ Lupus
- ☐ Ankylosing spondylitis
- ☐ Immune suppression such as from chemotherapy, organ transplant, etc.
- ☐ 3 or more months use of steroid medications or intravenous drugs (past or recent)

Family history

☐ Autoimmune disorders ☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Kidney disease ☐ Mental illness ☐ Seizure disorder

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature ______________________________ Today's date:_____/_____/_____

If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:

Name ______________________Relationship ______________ Today's date:_____/_____/_____

John W. Petersen, D.C.
North Maple Grove Chiropractic
9505 Blackoaks Lane North
Maple Grove Minnesota 55311
763-420-4111 fax 763 420-4145
johnpetersen.net

RECORDS RELEASE

I authorize the release of my records/x-rays or copies of such to the office of NORTH MAPLE GROVE CHIROPRACTIC, 9505 Blackoaks Lane No. Maple Grove, MN 55311.
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:_____________________

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 manipulations that 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:____________________

INSURANCE INFORMATION

Your insurance is an agreement between you and your insurance company. Some insurance plans have limited benefits, which we cannot know in advance. Our office will go to extreme lengths to make sure you get your maximum benefit from your insurance. If all of our efforts fail, you may be responsible for some visit charges.
PATIENT SIGNATURE:____________________________DATE:_____________________

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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 HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractor 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 not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to 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. For your security and right to privacy, all staff has been trained in this 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. 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 care.

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

________________________________ ________________________________

Signature of Patient Date