

Patient History

Patient Name: Today's Date:
Date of Birth: Age: Height Weight Sex: M F
Home Address: City: State:
Home Phone #: Work Phone #: Cell Phone #:
E-mail Address: Drivers License #:
Marital Status: Married / Divorced / Single / Widowed Spouse's Name:
First Names & Ages of children:
Occupation: Employer:
In Event of Emergency, who should we contact?
Relationship: Phone #(s)

Social Security Number: / / Is Medicare your primary Insurance? Yes No
Primary Insurance Company:
Insurance Policy #: Group #:

Would it be OK for us to contact your Family Physician or Specialist to coordinate care? Yes No
Physician Name: Phone #:
How did you hear about us? Screening or Scan / Printed Ad / Drive by / Internet / Referral
Who may we thank for referring you?

Why are you seeking care? or Physical problem(s) you would like examined. (Please list all your concerns)

What caused your condition: Auto Accident or Work Related Injury Fall/Trip/Slip where?
Overexertion/Lifting/Pulling Repetitive Movements/Posture
Gradual Onset Other

Have you retained an attorney or filed a Worker's Compensation claim? Yes No
Date when symptoms first appeared? How do these symptoms affect your life or lifestyle?

What makes the symptoms worse?
What makes the symptoms better (i.e., relieves symptoms)?
Did your symptom begin: Gradually Suddenly Progressed over time
If painful, circle quality of pain: Dull/Achy Sharp/Stabbing Burning Throbbing Electrical
Does the pain radiate into your: Arm Leg Head Does not radiate Other

Do you experience numbness or tingling? Yes No If yes, % of time: 100% 75% 50% 25% 10%

Please mark an "X" on the scale below to indicate the intensity of your discomfort.

Right now: No Discomfort 1 2 3 4 5 : 6 7 8 9 10 Worst Possible Discomfort
Average: No Discomfort 1 2 3 4 5 : 6 7 8 9 10 Worst Possible Discomfort
At Worse: No Discomfort 1 2 3 4 5 : 6 7 8 9 10 Worst Possible Discomfort

How have you already tried to resolve this problem?

- Over The Counter Medication Prescription Medication Another Doctor Surgery
Physical/Massage Therapy Chiropractic Acupuncture Nutrition, Herbs, etc.
Other:

Have you ever been treated by a Chiropractor before? Yes No Are you being treated now? Yes No

How committed are you to schedule your Time, Lifestyle, and Finances to get this problem under control?

Least- 1 2 3 4 5 : 6 7 8 9 10 -Most

Name: _____

CONFIDENTIAL HEALTH HISTORY

Medications you are currently taking: _____

Nutritional Supplements you are currently taking: _____

Any known allergies (Drugs, Antibiotics, Food, Environment) _____

Any sensitivities (Cats, Dogs, Food, Perfumes, Environment) _____

Have you ever had surgery or been hospitalized? Yes No Explain: _____

List all auto accidents with dates: _____

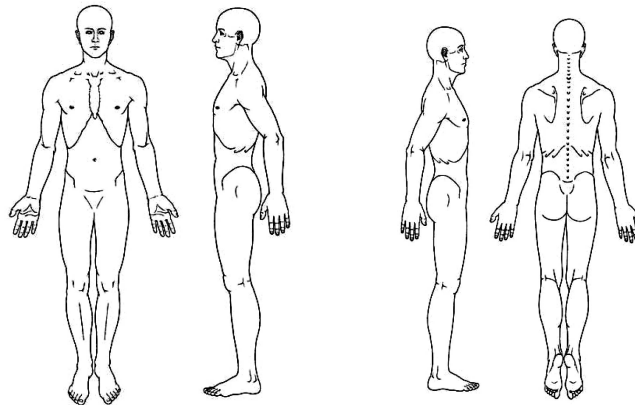
Do you smoke? Yes No ____ packs a day Do you drink alcohol? Yes No ____ times per week

Are you pregnant? Yes No Do you have any metallic implants, pacemakers, metallic sutures, etc.? Yes No

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.

<p>GENERAL AND/OR CURRENT CONDITIONS</p> <input type="checkbox"/> Recent accident such as a fall, whiplash, or blow to the head <input type="checkbox"/> Back/Neck problems <input type="checkbox"/> Muscle spasms <input type="checkbox"/> Restricted movement <input type="checkbox"/> Arm, shoulder, elbow or hand problem (circle) <input type="checkbox"/> Leg, hip, knee or foot problem (circle) <input type="checkbox"/> Headaches or migraines <input type="checkbox"/> Sinus problems <input type="checkbox"/> Depression, Nervousness or Anxiety <input type="checkbox"/> Difficulty dealing with stress <input type="checkbox"/> Dizziness Vertigo or Fainting <input type="checkbox"/> Vision or Hearing problem <input type="checkbox"/> Sleeping trouble <input type="checkbox"/> Breathing trouble or Asthma <input type="checkbox"/> Digestive disorder or Nausea <input type="checkbox"/> Heartburn/Acid Reflux <input type="checkbox"/> Menstrual problems <input type="checkbox"/> Jaw or mouth problem <input type="checkbox"/> OTHER: _____	<p>DIAGNOSED CURRENT CONDITONS</p> <input type="checkbox"/> Born with bone or joint disorder <input type="checkbox"/> Degenerative arthritis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Compression fracture <input type="checkbox"/> Heart attack or heart disorder <input type="checkbox"/> History of Stroke or Aneurysm <input type="checkbox"/> Neuritis <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Gout <input type="checkbox"/> Lupus <input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc. <input type="checkbox"/> 3 or more months of steroid medications or intravenous drugs (past or present) <input type="checkbox"/> Tuberculosis, Hepatitis or HIV <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Thyroid or hormone disorder <input type="checkbox"/> High blood pressure <input type="checkbox"/> Convulsions/epilepsy <input type="checkbox"/> Allergies: _____ <input type="checkbox"/> OTHER: _____	<p>CURRENT OTHER ISSUES</p> <input type="checkbox"/> Difficulty swallowing because of neck pain <input type="checkbox"/> Pain or electric shocks in arms or legs when moving neck <input type="checkbox"/> Leg pain worse with exercise <input type="checkbox"/> Numbness of inner thighs <input type="checkbox"/> Back pain with urinary problems <input type="checkbox"/> Severe pain that interrupts sleep <input type="checkbox"/> Constant pain that doesn't improve by changing positions or by lying down <p>SPECIFIC CURRENT CONDITIONS</p> <input type="checkbox"/> Poor balance <input type="checkbox"/> Loss of bowel or bladder control <input type="checkbox"/> Blurred or double vision, dizziness, nausea or faintness <u>when neck is in certain positions</u> <input type="checkbox"/> Memory loss after injury <input type="checkbox"/> Recent, unexplained weight loss <input type="checkbox"/> Recent progressive muscle weakness or shaking <input type="checkbox"/> Recent or current fever over 102°F <input type="checkbox"/> OTHER: _____
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Other Comments and/or Explanations: _____



Please mark off the areas of your complaint(s) on the diagram. Please use the following symbols on the diagram to accurately describe your condition:

PPP Pain **NNN** Numbness **TTT** Tingling **BBB** Burning **CCC** Cramping

Name: _____

Fill out this page ONLY if you have had an accident or injury

Type of accident: Automobile On-The-Job Injury Sports Slip/Fall Overexertion Repetitive Motion
Date of accident _____ Hour _____ AM PM Location of accident _____
Describe specifically how the accident occurred _____

What were your **immediate** symptoms after the accident? _____

Did you require hospitalization? Yes No Hospital: _____ Transported by ambulance? Yes No

Have you lost any days of work? Yes No If yes, how many? _____

Please check the symptoms you have noticed or that feel worse **since the accident**:

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Neck Pain/Stiff | <input type="checkbox"/> Fainting | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Heavy Head | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Tingling in Arms | <input type="checkbox"/> Tingling in Legs |
| <input type="checkbox"/> Ears ringing | <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Numbness in Arms | <input type="checkbox"/> Numbness in Legs |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Light Sensitive | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Other |

Did you have physical complains before the accident? Yes No Describe: _____

Auto Accident Details (required to file for your insurance benefits)

Year, Make, and Model of the vehicle you were in _____

Your Vehicle's Auto Insurance Co. _____ Insured's Name _____

Billing address: _____ Phone _____

Policy # _____ Claim # _____ Adjuster's Name _____

Other Vehicle's Auto Insurance Co. _____

Billing address: _____ Phone _____

Policy # _____ Claim # _____ Adjuster's Name _____

What was the estimated cost of repair to the vehicle you were in \$ _____

You were Driver Front passenger Back passenger (side: Driver's Passenger's Middle) Pedestrian

Road Conditions: Dry Wet Icy Gravel Road Visibility Outside: Good Moderate Poor

At impact, was your vehicle Stopped Moving (est. speed ____ MPH) Direction headed: N S E W

At impact you were looking Straight ahead To the side (Right Left) Over my shoulder (Right Left)

If your car was struck, which side(s) was hit? Front Rear Driver's side Passenger's side

Did the vehicle you occupy strike something else during the collision? Yes No What _____

If you struck another vehicle/object, was it Stopped Moving (speed? ____ MPH)

Who was at fault for the accident? You Driver of car you were in Other Driver Undetermined

Were you wearing your seatbelt? Yes No What type? Lap Shoulder Both Child's seat/booster

Did the Airbag inflate? Yes No Did your body strike any part of the vehicle? Describe _____

Did you lose consciousness? How long _____ Did you brace yourself for the collision? Yes No

Have you been in previous auto accidents? Yes No Describe: (date & injuries) _____

Have you completed and returned an "Application for Benefits" form to your insurance company? Yes No

Have you retained an attorney for this case? Yes No Name _____

On-The-Job Accident Details

Your Employer's Worker's Comp. Insurance Co. _____

Billing address: _____ Phone _____

Policy # _____ Claim # _____

Did you report the injury? Yes No Supervisor Name _____

Shift _____ Hours/day _____ Normal capacities: Lifting ____ lbs; Floor to Waist ____ lbs; Overhead ____ Carrying ____ lbs

Have you seen another health care provider for this injury before today? Name _____

Have you filed a Worker's Compensation claim? Yes No

Name: _____

Informed Consent

Chiropractic

Chiropractic seeks to restore health through natural means without the use of drugs or surgery. This gives the body a maximum opportunity to utilize all of its natural recuperative powers. The success of the chiropractic physician's procedures often depends on environment, underlying causes, the time symptoms have been present, and physical and mental conditions of the patient, etc. Sometimes the response is phenomenal. In most cases, there is a more gradual, but quite satisfactory response.

Consent To Chiropractic

I hereby request and consent to the performance of a clinical analysis which may consist of examination, diagnosis, adjustments, diagnostic X-rays, and/or other chiropractic/alternative procedures on me (or the patient named below, for whom I am legally responsible) by Dr. Michael K. Lindstrom, D.C. or other designated persons who now or in the future treat me while employed by, or associate with, Dr. Lindstrom and/or his business. I understand that there is the unlikely possibility of adverse events from examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains, and increased symptoms and pain, or no improvement of symptoms or pain. When acupuncture with needles is performed, adverse effects can include, but not limited to bruising, bleeding or infection. Nutritional supplements may occasionally be associated with adverse effects when taken with some medications. I therefore agree to fully disclose to Dr. Lindstrom all medications and supplements that I now take or may take hereafter. Furthermore I agree to inform Dr. Lindstrom immediately if I suspect that **any** adverse health effect has or is occurring and will not try to diagnose it on my own accord. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time based on the facts then known, is in my best interest. Should I ask any questions regarding risk or care, they will be explained to me upon my request before any procedure or examination is attempted. I acknowledge that no guarantees or promises have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

Our Privacy Policy

The office of Dr. Michael K. Lindstrom, D.C. is committed to upholding the security and confidentiality of personal information that you provide. This policy covers information including personal, financial, or health information about a consumer or customer relationships. We do not share or sell patient information with anyone outside our office without your written consent. For training and other reasons, patient/consumer contacts may be audio recorded. I hereby authorize that my records (or the records of the person for whom I am legally responsible) consisting of but not limited to my records of evaluation, diagnosis, and treatment with the office of Dr. Lindstrom, may be forwarded to other physicians, specialists, therapists, or my insurance company representatives, who are also involved in my healthcare (unless I have otherwise indicated). I retain the right to withdraw (in writing) any authorizations at any time. I understand that Dr. Lindstrom may provide regular care in a semi-open treatment format and that if I feel uncomfortable or have confidential information to share, I will request a private room. I understand that there may be other Rights and Responsibilities not listed here and I will ask if I have any questions.

Payment for Services

I hereby acknowledge that I am responsible for any and all indebtedness to Dr. Michael K. Lindstrom, D.C. for services performed or products received through *Lindstrom Chiropractic & Integrative Health* and/or associates. Unless other written financial arrangements are made, I agree to pay for all services or products at the time I consent to and/or receive them. Any exceptions must be agreed upon prior to incurring any further indebtedness between Dr. Lindstrom and myself. Any relationships between my insurance company and/or any other third party and me, are solely my responsibility (unless required otherwise by law.)

To The Patient

Please discuss any questions or problems with the doctor **before** signing this informed consent / statement of policy.

By signing below, I have read, or have had read to me, this document. I am freely making an informed decision that I agree to the above Consent to Chiropractic, Privacy Policy, and Payment for Services. I certify that the information I have provided is accurate and is correct to the best of my knowledge. I acknowledge the receipt of the federally required Notice of Privacy Practices. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. A photocopy of this document shall be considered as effective and valid as the original document.

Patient or Guardian's Signature _____ Date _____

Patient's Name (PRINTED): _____