217 Plum Street, Suite 120
Red Wing, MN 55066
651.385.5999

Health Within
Chiropractic & Acupuncture

Personal Information

Name:_____ Today's Date:_____
Last First MI

Birthdate: _____ Gender: _____ Sex: M F Marital Status: Single Married Separated Divorced Widowed
(mm/dd/yy)

Address: _____
Street City State Zip

Phone: (Cell) _____ (Home) _____ (Work) _____

E-Mail: _____

Emergency Contact: _____ Relation:_____ Contact #: _____

Case Type (circle) : Cash Medical Assistance Medicare Medica Blue Cross Preferred One

Health Partners Work Comp PI/Auto Other: _____

Employment Information

Employer Name:_____ Phone:_____

Your Occupation:_____

Employer Address:_____

Insurance Information

Name of Insurance Company:_____

Policy Holder Name: _____ **DOB:** _____
Last First MI (mm/dd/yy)

Mem/ID #: _____ Group #: _____

Claim #: _____

Address:_____
Street City State Zip

Phone #: _____ Fax #: _____

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Health History Form

Name:_____ Date:_____

1. **Chief Health Concerns:**

2. **Medications and/or Nutritional Supplements you are currently taking:**

*Please bring in a copy of potential side effects of each medication you are taking.
Contact your pharmacy for this information**.**

Height: _____ Weight: _____ Blood pressure: _____

Exercise: Do you exercise regularly? □ Yes □ No What kind of exercise? _____
How long (minutes)? _____ How often? _____

Diet: How would you rate your diet? □ Good □ Fair □ Poor
Would you like advice on your diet? □ No □ Yes

Sleep: How many hours do you sleep? _____ Is your sleep disturbed at the same time each night? What time?_____

Time of day with most energy/least symptoms:
□ 7 am – 9 am □ 9 am – 11 am □ 11am – 1pm
□ 1 pm - 3 pm □ 3 pm – 5 pm □ 5pm – 7pm
□ 7 pm - 9 pm □ 9 pm – 11 pm □ 11pm – 1am
□ 1 am – 3 am □ 3 am – 5 am □ 5am – 7am

Time of day you feel worst, or symptoms are aggravated:
□ 7 am – 9 am □ 9 am – 11 am □ 11am – 1pm
□ 1 pm - 3 pm □ 3 pm – 5 pm □ 5pm – 7pm
□ 7 pm - 9 pm □ 9 pm – 11 pm □ 11pm – 1am
□ 1 am – 3 am □ 3 am – 5 am □ 5am – 7am

Tobacco Use: Smoke cigarettes: □ Never □ No □ Yes (If you never smoked please go to alcohol use question now)
Quit date: _____ How many years did you smoke? _____ Approximately how many packs a day did you smoke? _____
Current smoker: Packs/day: _____ # of years: _____ Other tobacco: □ Pipe □ Cigar □ Snuff □ Chew

Alcohol Use: Do you drink alcohol? □ No □ Yes # of drinks/week: _____ □ Beer □ Wine □ Liquor

CHECK IF YOU HAVE HAD:

□ Pneumonia	□ Mumps	□ Anemia	□ Heart Disease	□ Arthritis	□ Eczema
□ Rheumatic Fever	□ Small Pox	□ Measles	□ Thyroid	□ Epilepsy	□ Stroke
□ Polio	□ Chicken Pox	□ Diabetes	□ Influenza	□ Mental Disorders	□ HIV/AIDS
□ Tuberculosis	□ Whooping Cough	□ Cancer	□ Pleurisy	□ Lumbago	

Is stress a contributing factor to your health? □ No □ Yes
Major cause of stress:_____

REVIEW OF SYMPTOMS: Please mark the box and/or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.

General
___ Unexplained weight loss / gain
___ Unexplained fatigue / weakness
___ Fall asleep during day when sitting
___ Fever, chills
___ Migraines
___ **No problems**

Ears/Nose/Throat
___ Nosebleeds, trouble swallowing
___ Stuffed nose/Sinus problems
___ Frequent sore throat, hoarseness
___ Ear Aches
___ Hearing loss/difficulty
___ Dental problems
___ **No problems**

Eyes
___ Change in vision / eye pain / redness
___ **No problems**

Cardiovascular
___ Chest pain / discomfort
___ Palpitations
___ Short breath
___ Blood pressure problems
___ Irregular Heart Beat
___ Heart Problems
___ Vericose veins
___ Ankle swelling
___ Stroke
___ **No problems**

Respiratory
___ Cough / wheeze
___ Loud snoring / altered breathing during sleep
___ Lung Problems/ Congestion
___ Short of breath with exertion
___ **No problems**

Gastrointestinal
___ Heartburn / reflux / indigestion
___ Blood or change in bowel movement
___ Constipation
___ Poor/Excessive appetite
___ Excessive thirst
___ Frequent Nausea
___ Vomiting
___ Diarrhea
___ Hemorrhoids
___ Liver problems
___ Gall Bladder trouble
___ Weight trouble
___ Abdominal cramps
___ **No problems**

Genitourinary
___ Bladder trouble
___ Painful urination
___ Discolored urine frequency
___ **No problems**

Musculoskeletal
___ Neck pain
___ Back pain – upper or lower
___ Pain between shoulders
___ Arm pain
___ Jaw pain
___ General stiffness
___ Muscle / joint pain
___ **No problems**

Endocrine
___ Heat or cold sensitivity
___ **No problems**

Allergic/Immune
___ Hay fever / allergies
___ Frequent infections
Please list any allergies:
_____
___ **No problems**

Psychiatric
___ Anxiety / stress / irritability
___ Sleep problem
___ Lack of concentration
___ **No problems**

Hematologic/Lymphatic
___ Swollen glands
___ Easy bruising
___ **No problems**

Neurological
___ Headache
___ Memory loss
___ Fainting
___ Dizziness
___ Numbness / tingling
___ Unsteady gait
___ Frequent falls
___ **No problems**

Women only
___ Pre-menstrual symptoms (bloating cramps, irritability)
___ Problem with menstrual periods
___ Hot flashes / night sweats
___ **No problems**

Total number of pregnancies: _____
Number of births: _____
Date of last menstrual period:
_____
Age of first period: _____
Age of menopause: _____

What health conditions are found in your family? (parents, siblings, children)

___ Cancer
Who & Type:_____
___ Diabetes
Who & Type:_____
___ Thyroid Condition
Who & Type:_____
___ Arthritis
Who & Type:_____
___ Heart Disease
Who & Type:_____

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Privacy Notice

I acknowledge that I have received the "notice of Privacy Practices" forms. This authorization and assignment will remain in effect until revoked by me in writing. If you have not received it, please ask.

_____ _____

Patient Signature **Date**

Informed Patient Consent

I, the undersigned, a patient at this office, hereby authorize Dr. Scott Ketterling D.C., Dr. Michael Swinarski D.C. and Dr. Katie Hudson D.C., to proceed with any treatment that may be necessary. Furthermore, any risks involving chiropractic manipulation will be explained to me upon request.

_____ _____

Patient Signature **Date**

_____ _____

Parent/Guardian if Minor **Date**

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Assignment of Insurance Proceeds

If you have health insurance, please sign this assignment of benefits. By agreeing to this assignment we will direct your insurance company to make any payments for your chiropractic, physiotherapy rehabilitation, x-rays, diagnostics testing or any other reimbursable treatment of evaluations you receive to our clinic directly.

In exchange for these services and supplies rendered, I do assign Health Within Chiropractic Insurance proceeds, including accident and health insurance, Minnesota no-fault benefits and liability claim awards up to the amount of any unpaid balance on my account, including interest. In giving this assignment, I acknowledge that I will be responsible for the amount of any remaining balance with interest.

Signature_____Date_____

Records Release Authorization

To: Health Within Chiropractic and Acupuncture

You are authorized to release any information contained in my file to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered to me by you or any member of your clinic acting on your behalf including any contracted billing company.

Signature:_____Date_____