Christianson Chiropractic, PLLC
New Patient Case History

Medical History

If female, are you pregnant? __Y __N __Not Sure If no or not sure, date of your last menstrual period: _____

List all medications you are currently taking, including over-the-counter medications and supplements: _____

_____

Are you allergic to any medications? __Y __ N __ Not Sure Please list: _____

_____

Have you ever had any surgeries or hospitalizations? __Y __N Please list:

Type of Hospitalization/ Surgery: Date: Type of Hospitalization/Surgery: Date:

_____ _____ _____ _____

_____ _____ _____ _____

Do you have a family physician? __Y __N Name of physician: _____

Phone: _____ Clinic Name: _____ City/State: _____

Do you have, or have you ever had, any diseases or medical problems not listed? __Y __N If so, please list:

_____

_____

Have you ever had: __ Motor Vehicle Injury __ Sports Injury __ Work Injury __ Slip & Fall Injury

If yes, please explain: _____

_____

Any additional information you would like the doctor to know about before beginning care at this office: _____

_____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING SECTION:

Personal Injury / Workers Compensation / Auto Accident

Date of Accident: _____ Time: _____ __AM __PM Location: _____

How did the accident occur? __ Auto Collision __ On-the-Job Injury __ Other: _____

Please describe the accident or injury: _____

_____

If work related, did you report the injury to your supervisor or employer? __Y __N

If work related, name and phone number of supervisor or authorized person: _____

If auto accident, were you the: __Driver __ Passenger __ Pedestrian

If auto collision, were you struck from: __Behind __Right Side __Left Side __ Front __Vehicle was parked

If auto accident, did your vehicle strike the other(s) involved? __Y __N Or did the other vehicle strike yours? __Y __N __Undetermined

Did your airbag deploy? __Y __ N Were you wearing a seatbelt? __Y __N

Did your body strike any objects in the vehicle? __Y __N Please list objects: _____

Did you lose consciousness from the accident? __Y __N Did Police / Ambulance / Fire respond to the accident? __Y __N

Were you taken to the hospital following the accident? __Y __N Was a report filed on the accident? __Y __N

Was work time lost due to the accident? __Y __N If yes, date you returned to work: _____

Do you have an attorney who has advised you in this case? __Y __N Attorney's Name: _____

Attorney's Address: _____ Attorney's Phone #: ( ) _____

Christianson Chiropractic, PLLC
New Patient Case History

Patient Information

Name: _____ Date: _____
Address: _____ City/State/Zip _____
Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____
Social Security #: _____ Birth Date: _____ Age: _____ Sex: __ M __ F
Email: _____ Marital Status: __ S __ M __ D __ W Spouse's Name: _____
Occupation: _____ Employer's Name: _____
Work Address: _____ City/State/Zip: _____
How were you referred to this office? _____

Emergency Contact

Name: _____ Relation: _____
Home Phone: ( ) _____ Cell Phone: ( )_____ Work Phone: ( ) _____
Address: _____ City/State/Zip: _____

Authorization & Assignment

I authorize Christianson Chiropractic, PLLC to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amount Christianson Chiropractic, PLLC does not collect from insurance proceeds (whether it be all or part of what is due) I personally owe.

I the undersigned do hereby appoint Christianson Chiropractic, PLLC authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by this clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. 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 my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Patient's Signature: _____ Date:_____

Informed Consent & Privacy Notice

I hereby authorize physicians and staff at Christianson Chiropractic, PLLC to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct and to the best of my knowledge. I will not hold my doctor or any staff member at Christianson Chiropractic, PLLC responsible for any errors or omission that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptoms, condition or disease as a result of treatment in this office An attempt to provide you with the very best of care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care

Soreness – Chiropractic adjustments and therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort

Soft Tissue Injury – Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, or other soft –tissue injury.

Rib Injury – Manual adjustment to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Stroke – Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems – There are occasionally other types of side effects associated with chiropractic care. While there are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have the chiropractic treatment administered.

I, the undersigned, hereby authorize Christianson Chiropractic, PLLC to administer treatment as necessary to my (Son/ Daughter),

Son/ Daughter's Name: _____

Effective Date: *This notice is in effect as of May 1, 2008.*

__ I understand that I am entitled to a copy of Christianson Chiropractic, PLLC's *Notice of Privacy*, but **do not** wish to receive a copy.

__ I understand that I am entitled to a copy of Christianson Chiropractic, PLLC's *Notice of Privacy,* and **do** wish to receive a copy.

By signing, you certify that you have received notice and that all of your questions have been answered to your satisfaction in language that you can understand.

Patient's Signature: _____ **Date:** _____

Family History

Has any blood relative **ever** had the following (**please circle):**

Breast Cancer	yes/no	Heart Disease	yes/no	Diabetes	yes/no
High Blood Pressure	yes/no	Depression	yes/no	Lung Cancer	yes/no
Kidney Disease	yes/no	Anxiety	yes/no	Arthritis	yes/no
Skin Cancer	yes/no	Stroke	yes/no	Allergies/Asthma	yes/no

Other: _____

For any answered yes, please provide details: Which relative, their age, how long they've had it, and if they are alive or deceased.

_____
_____
_____
_____
_____
_____
_____

Social History

Do you exercise? _____ How often? _____ What kind? _____

How is your diet? Please describe: _____
_____
_____

How much water do you drink (glasses/day)? _____0-2 _____2-4 _____4-8

Do you drink caffeine (pop, tea, energy drinks, or coffee)? _____ Never _____Occasionally _____Often

Do you drink alcohol? _____ Never _____Occasionally _____Often

Do you smoke? _____ How much? _____

Stress level: _____Low _____Medium _____High

How many hours of sleep do you get per night on average? _____hours

Quality of sleep: _____Poor _____Moderate _____Great