ADULT (18+)

7815 3rd St. N, Suite 102, Oakdale, MN 55128
651.400.7777

PATIENT MR# _____ DATE OF FIRST VISIT: _____ /_____ /_____

Thank you for choosing Big Idea Chiropractic. We are committed to providing you and your family the highest quality of chiropractic care so you may enjoy an active and healthy lifestyle. Prior to your consultation, please complete the following paperwork as thoroughly as possible in order for us to gain a clear understanding of your health goals. We will require a photocopy of your DRIVER'S LICENSE (or government identification) and INSURANCE CARD for our records. We comply with all federal privacy standards. As such, all information you provide is confidential.

PERSONAL INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Nickname: _____ DOB: _____ /_____ /_____ Age: _____ Gender: _____

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Email: _____

Cell # _____ Home # _____

What is your preferred method of communication? ☐ Email ☐ Text ☐ Call

Would you like to receive email reminders regarding appointments? ☐ Yes ☐ No

Would you like to receive text reminders regarding appointments? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name (if applicable): _____

How did you find Big Idea Chiropractic? _____

If referred, whom may we thank? _____

HEALTH HISTORY

Do you smoke? ☐ Never ☐ Occasionally ☐ Regularly ☐ I've quit

Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Regularly ☐ I've quit

Do you exercise? ☐ Never ☐ Occasionally ☐ Regularly ☐ I've quit

Have you had any major illnesses? ☐ Yes ☐ No

Is yes, please explain: _____

_____

Have you had any surgeries? ☐ Yes ☐ No

If yes, please explain: _____

_____

Have you had any serious falls or accidents? ☐ Yes ☐ No

If yes, please explain: _____

_____

Have you suffered any emotional traumas? ☐ Yes ☐ No

If yes, please explain: _____

_____

Have you been involved in any motor vehicle accidents? ☐ Yes ☐ No

If yes, please explain: _____

_____

Have you suffered any concussions?

☐ Never ☐ One time only ☐ Multiple times ☐ I think so, but I was never evaluated

PREVIOUS CHIROPRACTIC CARE

Have you been under chiropractic care as an adult?

☐ Never ☐ One time only ☐ A few times only ☐ Once in a while ☐ Regularly

If you have, what was the reason? _____

What were the results?

☐ I got worse ☐ No change ☐ Fair ☐ Good ☐ Excellent

What is the approximate date of your last chiropractic adjustment? _____

Do you have any reservations regarding chiropractic care? ☐ Yes ☐ No

If yes, please explain: _____

_____

MEDICATIONS & SUPPLEMENTS

Please list any prescription medications, over-the-counter medications, and supplements you are currently taking. Include the reason and how long you have been taking it.

1. Name: _____ Reason: _____

   For how long? _____

2. Name: _____ Reason: _____

   For how long? _____

3. Name: _____ Reason: _____

   For how long? _____

4. Name: _____ Reason: _____

   For how long? _____

5. Name: _____ Reason: _____

   For how long? _____

REVIEW OF SYSTEMS

Please check all that apply

GENERAL
- Fever
- Chills
- Weight Loss
- Weight Gain
- Night Sweats
- Weakness
- Cancer

ENDOCRINE
- Cold intolerance
- Heat intolerance
- Excessive thirst
- Excessive urination
- Excessive sweating
- Flushing

EYES/VISION
- Corrective lenses/contacts
- Cataracts
- Itching
- Blindness
- Double vision
- Sensitivity to light
- Blind spots
- Tearing

EARS, NOSE, & THROAT
- Dizziness
- Frequent sore throat
- Diminished sense of smell
- Sinus infections
- Ear discharge
- Headaches
- Nosebleeds
- Ear pain
- Hearing loss
- Nasal congestion
- Ringing in ears (tinnitus)

RESPIRATION
- Cough
- Shortness of breath
- Wheezing
- Asthma
- Coughing up blood
- Sputum production

CARDIOVASCULAR
- High blood pressure
- Low blood pressure
- Varicose veins
- Leg pain
- Shortness of breath
- Heart murmur
- Racing heartbeat

GASTROINTESTINAL
- Belching/gas
- Difficulty swallowing
- Abdominal pain
- Black/tarry stool
- Abnormal stool
- Heartburn
- Ulcers
- Constipation
- Diarrhea
- Indigestion
- Hemorrhoids
- Rectal bleeding
- Loss of bowel control
- Loss of bladder control

FEMALE
- Frequent urination
- Vaginal discharge
- Cramps
- Abnormal vaginal bleeding
- Breast lump
- Breast pain
- Hormone therapy
- Urinary incontinence
- Burning urination
- Irregular periods
- Infertility
- Miscarriages
- I am currently pregnant
- I am currently not pregnant

MALE
- Burning urination
- Frequent urination
- Prostate problems
- Erectile dysfunction
- Hesitancy/dribbling
- Urinary incontinence

SKIN
- Change in skin color
- History of skin disorders
- Rash
- Hives
- Change in nail texture
- Hair loss
- Psoriasis

HEMATOLOGIC
- Bleeding
- Blood transfusion
- Fatigue
- Anemia
- Blood clotting
- Bruise easily
- Lymph node swelling

NERVOUS SYSTEM
- Limb weakness
- Facial weakness
- Numbness
- Seizures
- Stroke
- Dizziness
- Sleep disturbances
- Loss of consciousness
- Loss of balance
- Headache/Migraine
- Loss of memory
- Slurred speech

PSYCHOLOGICAL
- Bi-polar disorder
- Anxiety
- Depression
- Change in appetite
- Confusion
- Insomnia
- Mood changes
- Behavioral changes

DESCRIPTION OF YOUR CONDITION

What condition lead you to seek chiropractic care?

_____

_____

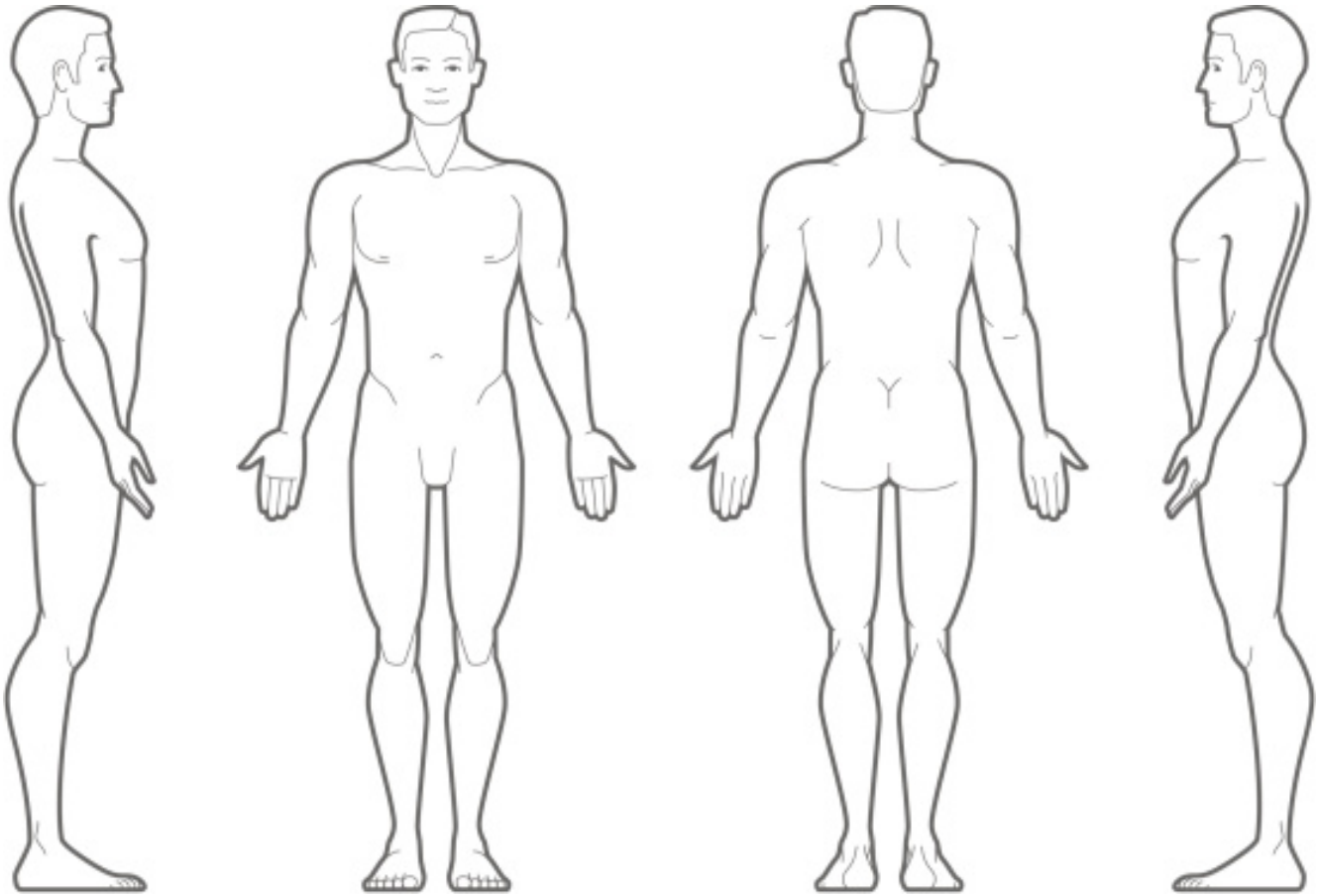
When did you first notice this condition?

_____

What were you doing when you first noticed this condition?

_____

Place an "X" on the diagram below where you are experiencing symptoms:



RIGHT FRONT BACK LEFT

Do the symptoms radiate or travel to another area? ☐ Yes ☐ No

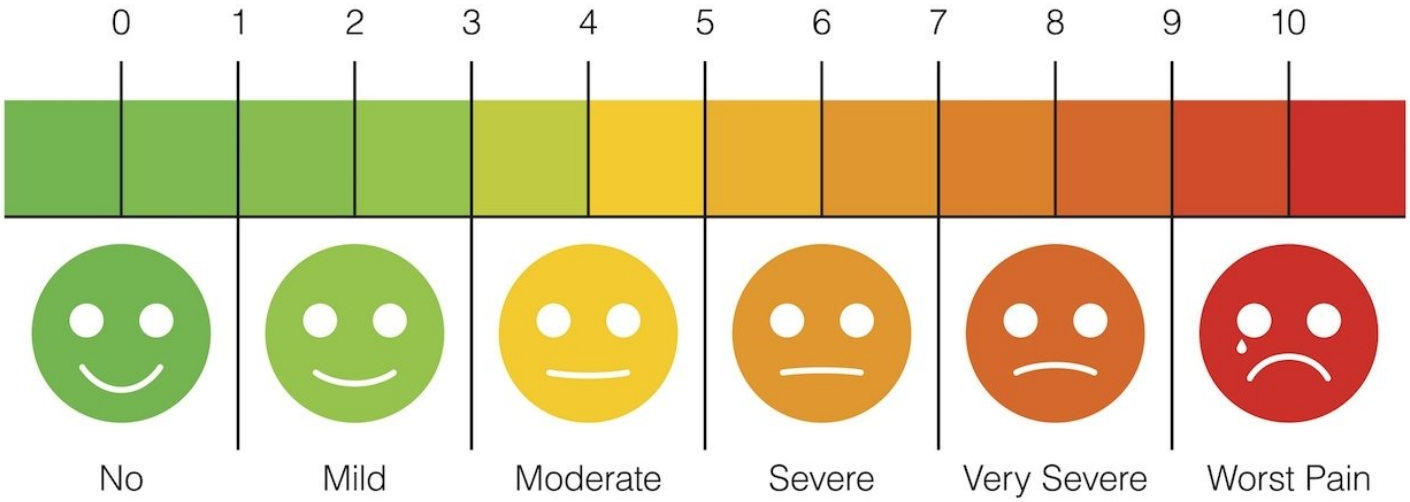
If yes, please describe: _____

Are you experiencing pain with this condition? □ Yes □ No

If yes, how would you describe the sensation of the pain? (mark all that apply)

□ Sharp □ Dull □ Achy □ Throbbing □ Burning □ Pins & Needles □ Numb

Please rate the intensity of your pain (circle a number):



How frequently do you experience symptoms?

□ Intermittently (0-25% of day) □ Occasionally (26-50% of day) □ Frequently (51-75% of day) □ Constantly (76-100% of day)

What makes your condition worse?

_____

_____

What makes your condition better?

_____

_____

What movements or activities are more difficult due to this condition?

_____

_____

Have you had this condition before? □ Yes □ No

FUNCTIONAL RATING INDEX

In order to properly assess your condition, we must understand how your neck and/or back problems have affected your ability to manage every day activities.
Please circle the answer which most closely describes your condition right now.

	0	1	2	3	4
PAIN INTENSITY	No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
SLEEPING	Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
PERSONAL CARE	No pain, no restrictions	Mild pain, no restrictions	Moderate pain, need to go slowly	Moderate pain, need some assistance	Severe pain, need 100% assistance
TRAVEL	No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
WORK	Can do normal work plus unlimited extra work	Can do normal work, no extra work	Can do 50% of normal work	Can do 25% of normal work	Cannot work
RECREATION	Can do all activities	Can do most activities	Can do some activities	Can do few activities	Cannot do any activities
FREQUENCY OF PAIN	No pain	Occasional pain (25% of day)	Intermittent pain (50% of day)	Frequent pain (75% of day)	Constant pain (100% of day)
LIFTING	No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
WALKING	No pain, any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain, any distance
STANDING	No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

SCORE: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC ADJUSTMENTS

The primary service rendered at Big Idea Chiropractic PLLC to you will be chiropractic adjustments, which are purposely intentioned movements of bones with the desired effect being to remove interferences to nerves, which then allows your body to use its innate ability to heal itself. Chiropractic adjustments also have the desirable effect enabling muscles, tendons, and ligaments to properly function and heal, and also allows blood flow to properly occur. Chiropractic adjustments are done by hand and may include either spinal and extremity bones. You may or may not hear an audible sound, which is just air being released from the joint space as bones are moved into their proper positions.

OTHER PROCEDURES

A physical examination will be performed to obtain a baseline level of functioning as well to partially determine an appropriate course of treatment and associated recommendations. The physical examination may include posture checks, range of motion testing, muscle strength testing, etc. Radiology is the use of x-rays to gain an inside perspective of the human body that cannot be obtained from a physical examination. By signing this form, you certify Dr. Clay Larson, DC has permission to perform an x-ray evaluation. **To the best of your knowledge, you are not pregnant and have been advised that x-rays can be harmful to an unborn child.**

BENEFITS OF CHIROPRACTIC CARE

The vast majority of chiropractic patients tend to achieve good to excellent improvement in their physical conditions with chiropractic care. Improvement can be measured in many different ways, including reduction in pain, increased range of motion, less stiffness, increased athletic performance, and many others. It must be remembered that different people respond differently to chiropractic care. Different people have pre-existing conditions and are of different ages and occupations (with different types of physical stress). Your situation is unique, and no guarantees are given.

RISKS INHERENT WITH CHIROPRACTIC CARE

As with any healthcare procedure, there are certain complications which may arise when chiropractic adjustments are performed. These complications include but are not limited to fractures of bones, disc injuries, dislocations, muscle strains, cervical myelopathy, strokes, radiation exposure, or costovertebral strains and separations. Some patients feel some stiffness and/or soreness following the first few days of treatment. Dr. Clay Larson, DC will make every reasonable effort during the examination to screen for contraindications to care, but remember it is your responsibility to inform him of any conditions that would not otherwise come to his attention.

PAYMENT AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this healthcare office will prepare any necessary reports and forms to assist me in receiving reimbursement from my insurance company which will be sent directly to me. However, I clearly understand and agree I am personally responsible for payment of any services rendered to me and charged directly to me.

_____ Date: _____

Signature of Patient or Patient's Legal Guardian

_____

Signer's Printed Name

PATIENT HEALTH INFORMATION CONSENT

At Big Idea Chiropractic PLLC, we want you to know how your Patient Health Information (PHI) is going to be used and your rights concerning those records. Before you begin any services at our clinic, you must read and sign this consent form stating you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this chiropractic clinic to use his or her Patient Health Information (PHI) for the purpose of chiropractic services, payment, and coordination of care. For example, the patient agrees to allow Big Idea Chiropractic PLLC to submit requested PHI to the health insurance company (or companies) provided to it by the patient for the purpose of payment. Be assured this clinic will limit the release of all PHI to the minimum required.

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 my request to know what disclosures have been made and submit in writing any further restrictions on the use of his or her PHI. Please note, however, this clinic 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 this patient at this clinic.

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 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 have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures within this clinic. Big Idea Chiropractic PLLC has taken all known precautions to assure records are not readily available to those who do not need access to them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policy procedures.

7. If the patient refuses to sign this consent for the purpose of chiropractic services, payment, and coordination of care, Big Idea Chiropractic PLLC has the right to refuse care.

_____ Date: _____

Signature of Patient or Patient's Legal Guardian

_____

Signer's Printed Name