Acu-Chiropractic New Patient Information

Contact Information

Mr./Ms./Mrs./Dr. First Name: ______________________ MI:________ Last Name: ______________________

Address: ______________________ City: ______________________ State: ________ Zip: ________

Telephone (Cell): ______________________ (Home): ______________________ (Work):______________________

Date of Birth: ____/____/________ Age: ______________________ SSN: ________-______-________

Employer: ______________________ Occupation: ______________________ Employer City: ______________________

Spouse's Name: ______________________ Spouse's Employer: ______________________ Spouse's Occupation: ______________________

Number of Children: ____________Emergency Contact: ______________________Phone:______________________

Guardian: ______________________ Name of the Insured: ______________________ Nickname: ______________________

Email: ____ **Referred By**: ______________________

Federal guidelines require/request the following: **Gender**: Male Female **Height :**________ft ______in **Weight:**________lbs.

Language: English Other______________ **Do you smoke?** No Yes, current everyday current some days former smoker

Race: Caucasian African American Native American Asian Other______________ **Ethnicity**: Non-Latino Latino

Payment Options

________**Out of Pocket** (When paid in full on same date as service, a same day discount will apply.) 2020 Pricing for patients not using insurance or not covered by insurance.

Same day discount: $65/$175 Effleurage: $10 Acupuncture: $25 Cupping/Graston Technique®: $35per area Kinesiology Taping: $6 per application or $20 per roll

I understand that if I choose to receive the treatment described above, I will be billed the chiropractor's usual fee, and I will be personally responsible for payment of any and all charges associated with this treatment.

Patient Signature: ____

________**Medical Insurance (Group/Private Pay)** (Acu-Chiropractic will take assignment for your chiropractic benefits.

All uncovered expenses, including co-payments, are to be paid at at time of service.) **Primary**______________________**Secondary**______________________

________**Medicare** (Medicare covered 80%, after your deductible has been met.)

________**Workers' Compensation** (WC is covered at 100% of the Minnesota mandated amounts. Patients are not responsible for any charges from a workers compensation claim.)

________ **Auto Insurance with Assignment** (Acu-Chiropractic will take assignment for your chiropractic benefits. All uncovered expenses, including co-payments, are to be paid at the time of service.)

Secondary Insurance (Acu-Chiropractic will submit to your secondary insurance after we have received your explanation of benefits from your primary insurance company.

HIPPA (Federal Law) and Acu-Chiropractic Policies

- If you are unable to keep your appointment, please notify the office 24 hours before your scheduled time. Acu-Chiropractic reserves the right to charge $45 to the individual directly for missed appointments. (initial) ____________ ★
- I have read and understand the contents of the following:
  - ◊ Informed Consent and Protected Health Information: (initial) ________ ★
  - ◊ Acupuncture, Graston Technique, Cupping and Massage Therapy Informed Consent: (initial)________ ★
- Acu-Chiropractic reserves the right to charge a fee for returned checks.
- Acu-Chiropractic will charge a 1.25% monthly interest fee for accounts over 90 days past due. The patient will be responsible for all fees if the account is sent to a collection agency.

Patient/Guardian's Signature: ____ Date: ______________________

4590 Scott Trail
Eagan, MN 55122
651.454.1000
651.454.4375 (fax)

Acu-Chiropractic Wellness Center, PA

Patient's Authorization to Release Medical Information

"I herby authorize Acu-Chiropractic Wellness Center, PA permission to attain my medical records."

★ **Please fill in your information in the box below:**

Patient's Name: ____

Signature: ____

Address: ____

____

____

Date of Birth: ____

To: ____ Date: ______________________

____

____

____

Attention: ____

Please send/fax:

□ Complete Medical Records

□ Radiology Report (s)

□ Other: ____

Thank you in advance for your prompt response.

Scott D. Sammon, DC

Adam C. Ebbers , DC

Laura E. Frerich, DC

Jennifer A. Schulz, DC

Name:

Chief Complaint (s): ____________________

How did it happen: ____________________

Date of injury or when this episode began: ____________________

Did symptoms develop from: Auto accident Work Related Neither

Progression: Sudden Gradual Comes and Goes

Frequency: Constant Frequent Intermittent Occasional

Change in pain since initial onset: Worse Same Better

Type: Pain Spasm Tender Sore Ache Stiff Weak Numb Dull Burning Tight

Does the pain radiate or tingle? No Yes, to shoulder to elbow to fingers to hip to knee to toes

Pain Level:	0	1	2	3	4	5	6	7	8	9	10
	No pain		Mild pain			Moderate pain			Intense pain		Unbearable pain Unable to function

What daily activities are difficult to perform (vacuuming, dressing, etc.)? ____________________

What makes your condition ***better***? Nothing Stretching Heat Standing Ice Sitting Movement Massage Rest Laying

What makes your condition ***worse***? Nothing Lifting Standing up Standing Walking Reaching Bending Sitting Movement Inactivity Laying

Symptoms are ***better***: AM Midday PM Do your symptoms wake you up at night? Yes No

Symptoms are ***worse***: AM Midday PM Any sudden unexplained weight loss or gain recently? Yes No

Have you had these complaints before? Yes No When?____________________

Any injuries to the area of concern: ____________________

What treatment have you previously had for this condition: ____________________

Have you had any imaging (x-ray, MRI)? Yes No When?________ What were they taken for?____________________

Home Treatment : Nothing Ice Heat Stretching Massage Pain Reliever Other________________

Circle any of the following that are difficult or painful:

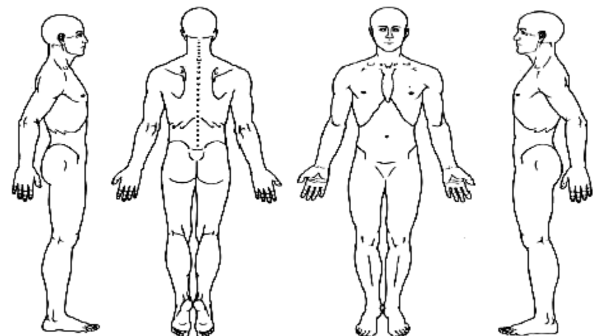
Standing >10 min	Coughing/Sneezing	Pushing	Stooping
Standing > 1 hour	Getting out of the car	Kneeling	Gripping
Walking short distance	Turning over in bed	Balancing	Pulling
Putting on shoes	Getting out of bed	Sitting	Reaching
Putting on clothes	Lying on stomach	Looking back	Climbing stairs
Bending forward	Lying on side	Sleeping	Sexual activity

Circle any nervous system complaints that apply:

Blurry vision	Dizziness	Numbness	Muscle Jerking
Ringing ears	Fainting	Loss of sleep	Pain going to fingers
Confusion	Paralysis	Low resistance	Pain going past knee

Circle Work Activities: Sitting Standing Lifting Computer Driving

Circle area (s) of concern or pain:



Headaches: Yes No Frequency:____________________

How long have you suffered from headaches: ____________________

Which side: Right Left Both

Location: Forehead Temple Behind eyes Back of head

Family History (including diabetes, heart disease, cancer): ____________________

List any accidents or surgeries: ____________________

Do you have any major health concerns: No Yes: ____________________

Name of Primary Care Physician and Clinic: ____________________

Medications you are taking AND dose: ____________________

____

Supplements you are taking: ____________________

Allergies (medications, environmental, etc.): ____________________

Have you been to a chiropractor before? No Yes, when ____________________

WOMEN: Are you pregnant? Yes No Date of last menses ____________________

How often do you consume:

Alcohol:	Daily	Weekly	Monthly	Occasionally	Never
Caffeine:	Daily	Weekly	Monthly	Occasionally	Never
Tobacco:	Daily	Weekly	Monthly	Occasionally	Never
Pain reliever:	Daily	Weekly	Monthly	Occasionally	Never

BP: / Pulse:

Has your condition affected the following areas? If yes, please explain when and what area was affected.

Sleep: No Yes, ____________________

Appetite: No Yes, ____________________

Social/Home Life: No Yes, ____________________

Work Life: No Yes, ____________________

Concentration: No Yes, ____________________

Have you ever had the following occur, if yes please explain when and what area was affected.

Fracture: No Yes, ____________________

Concussion: No Yes, ____________________

Stroke: No Yes, ____________________

Auto Accident: No Yes, ____________________

Review of Systems: Do you have any problems or conditions related to:

Eyes, Ears, Nose or Throat: No Yes, ____________________

Heart or Lungs: No Yes, ____________________

Digestive System: No Yes, ____________________

Urinary or Genital System: No Yes, ____________________

Nervous System: No Yes, ____________________

Mental Health: No Yes, ____________________

Other (autoimmune, skeletal, etc.): No Yes, ____________________

Circle if you have: Diabetes Arthritis High Blood Pressure Heart Disease Osteoporosis Thyroid issues Cancer