

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.) 2017 Pricing

Same day discount: \$62/\$149 Effleurage: \$10 Acupuncture: \$25 Graston Technique®: \$30per area Kinesiology Taping: \$5 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: _____

_____ **Major Medical Group/Private** (Acu-Chiropractic will take assignment for your chiropractic benefits. All uncovered expenses, including co-payments, are to be paid at the 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 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: _____

Acu-Chiropractic Wellness Center, PA
Patient's Authorization to Release Medical Information

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

"I hereby 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 _____

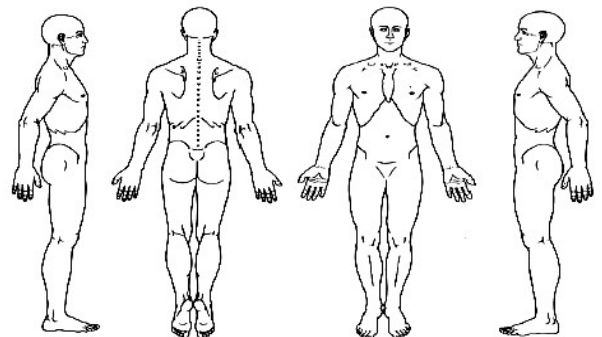
Circle any of the following that are difficult or painful:

- | | | | |
|------------------------|------------------------|--------------|-----------------|
| 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 |
| Ringin ears | Fainting | Loss of sleep | Pain going to fingers |
| Confusion | Paralysis | Low resistance | Pain going past knee |

Circle area (s) of concern or pain:



Circle Work Activities: Sitting Standing Lifting Computer Driving

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