

Acu-Chiropractic New Patient Information

Contact Information

Mr./Ms./Mrs./Dr. First Name: _____ MI: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone (Cell): _____ (Home): _____

Date of Birth: ____ / ____ / ____ Age: _____

Employer: _____ Occupation: _____ Employer City: _____

Spouse's Name: _____ Spouse's Employer: _____ Spouse's Occupation: _____

Number of Children: _____ Emergency Contact: _____ Phone: _____

Guardian: _____ Name of the Insured: _____ Preferred name: _____

Email: _____ **Referred By:** _____

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/\$190 Effleurage: \$15 Acupuncture: \$34 Cupping/Graston Technique®: \$35 per area Kinesiology Taping: \$8 per application or \$27 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.)

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:** _____

The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

Disagree

Agree

- | | | | |
|---|--------------------------|--|--------------------------|
| 1 My back pain has spread down my leg(s) at some time in the last 2 weeks | <input type="checkbox"/> | | <input type="checkbox"/> |
| 2 I have had pain in the shoulder or neck at some time in the last 2 weeks | <input type="checkbox"/> | | <input type="checkbox"/> |
| 3 I have only walked short distances because of my back pain | <input type="checkbox"/> | | <input type="checkbox"/> |
| 4 In the last 2 weeks, I have dressed more slowly than usual because of back pain | <input type="checkbox"/> | | <input type="checkbox"/> |
| 5 It's not really safe for a person with a condition like mine to be physically active | <input type="checkbox"/> | | <input type="checkbox"/> |
| 6 Worrying thoughts have been going through my mind a lot of the time | <input type="checkbox"/> | | <input type="checkbox"/> |
| 7 I feel that my back pain is terrible and it's never going to get any better | <input type="checkbox"/> | | <input type="checkbox"/> |
| 8 In general I have not enjoyed all the things I used to enjoy | <input type="checkbox"/> | | <input type="checkbox"/> |
| 9. Overall, how bothersome has your back pain been in the last 2 weeks ? | | | |

Not at all

Slightly

Moderately

Very much

Extremely

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Scored by staff:

Total score (all 9): _____ Sub Score (Q5-9): _____

Soft tissue therapies Questionnaire (Graston Technique®. IASTM and Cupping)

Please answer the following questions. If you have any questions, please speak with your clinician.

- | | | |
|---|-----|----|
| 1. Do you bruise easily? | Yes | No |
| 2. Do you bleed for a long period of time after you cut yourself? | Yes | No |
| 3. Are you taking blood thinners or anticoagulants? | Yes | No |
| 4. Do you take aspirin on a regular basis? | Yes | No |
| 5. Do you take cortisone on a regular basis? | Yes | No |
| 6. Do you have surgical implants in your body? | Yes | No |
| 7. Have you ever had inflamed veins, blood clots, or other vascular issues? | Yes | No |
| 8. Do you have diabetes, liver disease, heart disease, or kidney disease? | Yes | No |
| 9. Do you currently have any infections or open skin wound? | Yes | No |
| 10. Do you have uncontrolled high blood pressure or thrombophlebitis? | Yes | No |

Name: _____

Circle area (s) of concern or pain:

Chief Complaint (s): _____

How did it happen: Injury/Sudden Repetitive Overuse/Gradual Recurring

Mechanism of Injury (fall, etc.): _____

Date of injury or when this episode began: _____

Did symptoms develop from: Auto accident Work Related Neither

Frequency: Constant Frequent Intermittent Occasional

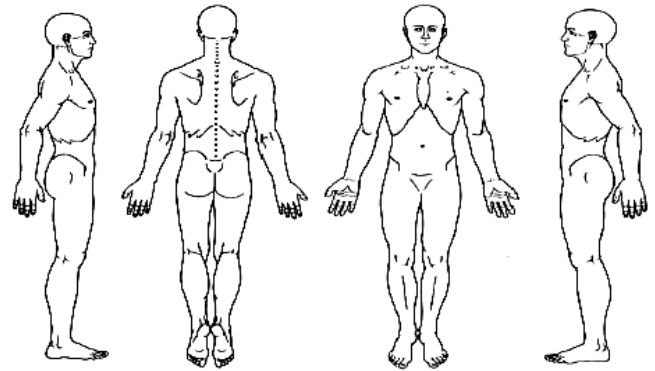
Is the pain the: **Same** no matter the position **Improve** or **Worsen** with a change in position or activity

Change in pain since initial onset: Worse Same Better

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

Pain Level: 0 1 2 3 4 5 6 7 8 9 10

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



What makes your condition **better**? Nothing Stretching Heat Ice Rest Movement Walking Massage Pain reliever

Symptoms are **better**: AM Midday PM

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

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

Daily activities are difficult to perform (vacuuming, exercise, etc.): _____

Previous episodes of the same symptoms: 0 1-4 5+ First Episode: _____ Most Recent: _____

Any injuries to the area of concern: _____

Previous treatment: Chiropractic Physical Therapy Injections Massage Surgery Other

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

Has your condition affected?

Sleep:	Yes	No
Appetite:	Yes	No
Social/Home Life:	Yes	No
Work Life/Concentration:	Yes	No

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 Walking Standing Lifting Computer Work Driving

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: _____

Supplements you are taking: _____

Allergies (medications, environmental, etc.): _____

What are your leisure activities or hobbies: _____

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

WOMEN: Are you pregnant? Yes, _____ weeks Maybe No

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

Height: _____

Weight: _____

Have you ever had the following?

Fracture: Yes No

Concussion: Yes No

Stroke: Yes No

Auto Accident: Yes No

Headaches: Yes No Frequency: _____ per week/month Occasional

Are your headaches new or different from headaches in the past: Yes No

Location: Forehead Temple Behind eyes Back of head

Side: Right Left Both

Triggers: Hormones Lack of Sleep Stress Foods Other _____

Review of Systems:

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