NEW PATIENT INFORMATION

Welcome to our office! Please complete all questions.

Name:	Date:	Height	Weight
Address:	City/State/Zip		
Home Phone:	Cell:	Work:	
Email Address:			
Birth Date:	Age:	Marital Status: M D W Single Separated	
Your Employer:	Occupation:		
Spouse's Name:	Spouse's Occupation:		
Children's Names and Ages:			
Favorite Hobbies or Interests:			
Methods of Payment for First Visit:	Cash	Check	Credit Card
Immediate Family History of :	Diabetes	Cancer	Heart Disease

Is today's visit for : __ Wellness Care __ Specific Problem What?_____
What are your health goals for today's visit and otherwise:

1) _____
2) _____
3) _____

Who may we thank for referring you?_____
Have you visited a chiropractor before?_____ Who?_____
Do you use any tobacco products?_____ How often?_____
Surgeries you have ever had:_____
Medications you currently take:_____
Pregnant?_____ Diagnosed with Cancer?_____ Type?_____
Do you have health insurance?_____Name of Company?_____
Are you experiencing or have you experienced any symptoms frequently this past year?

__ Low Back Pain	__Pain between shoulders	__Neck Pain	__ Arm/Leg Pain
__ Joint Pain/Stiffness	__Clicking Jaw	__General Stiffness	__ Dizziness
__ Nervousness	__Depression/Confusion	__ADD/ADHD	__ Fainting
__ Numbness/Tingling in Arms/Legs	__Fatigue	__Loss of sleep	__ Headaches
	__Asthma	__Severe Emotional Trauma	
__ Allergies	__ Diarrhea	__ Constipation	__ Heartburn
__ Chest Pain	__ High/Low Blood Pressure	__ Vision Problems	__ Stroke
__Menstrual Issues	__Breast Pain/Lumps	__ Prostate Problems	__Erectile Dysf

When was the last time you had a physical with your primary family doctor?_____
If you are in my office for a specific problem, what other treatment have you received?

_____

Many of our clients come to our office for wellness care. If you came here for a specific problem, please answer the following questions.

1. Which pain or condition that you are experiencing is the worst?
   _____
   _____
2. How long has it bothered you?_____
3. Vertebral subluxations can cause irritation to different fibers within nerves. Is your pain dull or sharp? _____
4. Subluxations can put pressure on the spinal nerves can cause pain that is either constant or occasional, which is yours? _____
5. Is it worse in the morning or afternoon?_____
6. Does it radiate in to an arm or leg or stay in one area? _____
7. Is there anything else you would like the doctor to know about your health?_____
   _____
   _____

History-- There are many ways conditions develop, some are from a big trauma others happen slowly over time. Help me learn how your body came to its present condition.

1. Do you know anything about your birthing process? Were you a forceps, suction, c-section baby?
   _____
2. Please list three memorable slip and falls that stick out in your memory
   a. _____
   b. _____
   c. _____
3. The average person has an auto accident every ten years. Please tell me about your most recent? _____
   Speed: _____ Front/Rear/Side Collision _____
   What kind of treatment did you receive?_____
   Any other accidents?_____
4. Most of our clients do work that is either repetitive, sedentary or physically taxing.
   a. What could be contributing to subluxation in your line of work?_____
   _____
   b. Please describe any stresses or strains at work not covered above _____
   _____
   c. What other types of employment have you had?_____
5. Please describe any stresses or strains you have had while participating in recreational activities or sports_____
   _____
6. Anything else you think I should know about you regarding stressors in your life or injuries that you have had?

Active Family Chiropractic - Dr Lori Goodsell

Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship

between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE DR LORI GOODSELL TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.
DATED THIS ____ DAY OF _____, 20___

_____ _____
Patient Signature **Doctor's Signature**

_____
Print Name

Remarks:

Active Family Chiropractic Privacy Policy

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03) I consent to the use or disclosure of my protected health information by Active Family Chiropractic P.A. for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Active Family Chiropractic, P.A.

I understand that analysis, diagnosis or treatment of me by Active Family Chiropractic P.A. may be conditioned upon my consent as evidenced by my signature below. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Active Family Chiropractic P.A.is not required to agree to the restrictions that I may request. However, if Active Family Chiropractic P.A. agrees to a restriction that I request, the restriction is binding on Active Family Chiropractic P.A. I have the right to revoke this consent, in writing, at any time, except to the extent that Active Family Chiropractic P.A. has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Active Family Chiropractic P.A. and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Active Family Chiropractic P.A. The Notice of Privacy Practices for Active Family Chiropractic P.A. is also posted in the waiting room at 1700 Niagara Lane Suite 300 Plymouth, Minnesota. This Notice of Privacy Practices also describes my rights and duties of the Active Family Chiropractic P.A. with respect to my protected health information.

Active Family Chiropractic P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Active Family Chiropractic P.A. and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Name	Patient Signature	Date