

# Lifestyle Chiropractic

821 Sibley Memorial Highway · Mendota Heights, MN 55118  
[www.lifestylechirocenter.com](http://www.lifestylechirocenter.com)  
(651) 406-4454

Progressive Chiropractic · Nutrition · Massage · Spinal Decompression

## ABOUT YOU

First Name: _____ Last Name: _____ Nickname: _____ Date of Birth: _____ Age ____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated Phone: (H) _____ (C) _____ Address: _____ _____ City: _____ Zip: _____ E-Mail: _____ <small>Lifestyle Chiropractic respects your privacy – your email is necessary for appt confirmations, it will not be shared or sold.</small> Social Security #: _____ Medical Doctor Info: Name: _____ Clinic or Hospital and City _____ _____	Names and Ages of Children: _____ _____ _____ Do you have insurance that may contribute to your care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check all that apply: <input type="checkbox"/> Medicare <input type="checkbox"/> Work Comp <input type="checkbox"/> Auto <input type="checkbox"/> Private Insurance: _____ Who may we thank for referring you to our office? _____ If you were not referred, how did you hear about us? <input type="checkbox"/> Internet <input type="checkbox"/> Drive-by <input type="checkbox"/> Lecture <input type="checkbox"/> Office-sign <input type="checkbox"/> Newspaper <input type="checkbox"/> Health screening, which one? _____ In case of an emergency, name and # of contact to call: _____
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### Why This Form is Important

As a full spectrum Chiropractic and wellness office, we focus on your ability to be healthy. Our goals are first to address the issues that brought you to this office, and second to offer you the opportunity for improved health potential and wellness. On a daily basis we experience physical, chemical, and mental stresses that can accumulate over time, resulting in a premature loss of health. Most times these stresses are not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have in your life, allowing us to assess any potential health challenges you may have.

**Please rate your overall Health Status** Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What are your health goals? \_\_\_\_\_

People see Chiropractic Doctors for a variety of reasons. Your Doctor will weigh your needs and desires when recommending a care plan to you. *Please check the type of care desired so we may be guided by your wishes whenever possible.*

- Relief Care: Symptomatic relief of pain or discomfort in the shortest amount of time possible.
- Corrective Care: Correcting and relieving the cause of the problem as well as relieving the symptoms.
- Comprehensive care: Bring whatever is malfunctioning in the body to the highest state of health possible.
- I want the Doctor to select the type of care appropriate for my condition.

Have you ever been put on a Health Development Program?  YES  NO

If Yes, by whom? \_\_\_\_\_

Are you healthier today than you were five years ago?  YES  NO

If yes, what have you done to improve your health? \_\_\_\_\_

Is your current condition a result of  an auto accident?  a work-related injury?  neither

Date of injury? \_\_\_\_\_

Have you had previous chiropractic care?  YES  NO

If yes, what was the doctor's name? \_\_\_\_\_

What was the approximate date of your last visit? \_\_\_\_\_

What was the duration of your care? \_\_\_\_\_

**Please describe below, your primary and secondary reasons for seeking care in our office.**

<b>Primary complaint</b> (list one only) _____ <i>(please use back of sheet if more room is needed)</i>	<b>Secondary complaint</b> (list one only) _____ <i>(please use back of sheet if more room is needed)</i>
When did you first experience this problem? _____	When did you first experience this problem? _____
How did this problem first begin? _____ _____	How did this problem first begin? _____ _____
How often do you experience this problem? <input type="checkbox"/> 1-2x/week <input type="checkbox"/> 3-4x/week <input type="checkbox"/> 5-6x/week <input type="checkbox"/> daily <input type="checkbox"/> other: _____	How often do you experience this problem? <input type="checkbox"/> 1-2x/week <input type="checkbox"/> 3-4x/week <input type="checkbox"/> 5-6x/week <input type="checkbox"/> daily <input type="checkbox"/> other: _____
Please grade the intensity of the problem: At best: 1 2 3 4 5 6 7 8 9 10 <i>(with 10 being</i> At worst: 1 2 3 4 5 6 7 8 9 10 <i>the worst)</i>	Please grade the intensity of the problem: At best: 1 2 3 4 5 6 7 8 9 10 <i>(with 10 being</i> At worst: 1 2 3 4 5 6 7 8 9 10 <i>the worst)</i>
How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)? _____ _____	How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)? _____ _____
Please describe the location. _____ _____	Please describe the location. _____ _____
Does this problem cause pain or numbness to travel to any other area? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, where? _____	Does this problem cause pain or numbness to travel to any other area? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, where? _____
Is this problem getting: <input type="checkbox"/> worse? <input type="checkbox"/> better? <input type="checkbox"/> staying the same? What seems to aggravate this problem? _____	Is this problem getting: <input type="checkbox"/> worse? <input type="checkbox"/> better? <input type="checkbox"/> staying the same? What seems to aggravate this problem? _____
What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, surgery)? _____	What have you tried to relieve this problem (i.e. interventions, treatments, aspirin, surgery)? _____

Have you seen other doctors for this problem? <input type="checkbox"/> YES <input type="checkbox"/> NO What treatment was given? How effective was the care? _____ _____ _____	Have you seen other doctors for this problem? <input type="checkbox"/> YES <input type="checkbox"/> NO What treatment was given? How effective was the care? _____ _____ _____
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Any additional complaints?? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Lifestyle / Social History**

**Medical History**

<p>Job Description: _____          _____          _____</p> <p>Work schedule: _____          _____</p> <p>Recreational Activities: _____          _____          _____</p> <p>Do you smoke cigarettes? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, how much? _____</p> <p>Do you drink alcohol? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, how much? _____</p> <p>Do you drink coffee? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, how much? _____</p> <p>Do you drink tea? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, how much? _____</p> <p>How regularly do you exercise?  <input type="checkbox"/> daily <input type="checkbox"/> ___x/week <input type="checkbox"/> occasionally <input type="checkbox"/> never          What kind of exercise do you do? _____          _____</p> <p>How many hours of sleep do you get on average?          _____</p> <p>On a scale of 1-10, please rate your stress level (1=none and 10=extreme):          Occupational _____ Personal _____</p> <p><b>Women Only-----</b></p> <p>Pregnancies and outcomes:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Date of pregnancy</th> <th style="width: 30%;">Outcome</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>When was your last period? _____</p> <p>Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> not sure</p>	Date of pregnancy	Outcome	_____	_____	_____	_____	_____	_____	_____	_____	<p><b>Please check any of the following illnesses you have had in the past with a P, and have currently with a C:</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td><input type="checkbox"/> Pneumonia</td> <td><input type="checkbox"/> Mumps</td> <td><input type="checkbox"/> Influenza</td> </tr> <tr> <td><input type="checkbox"/> Rheumatic Fever</td> <td><input type="checkbox"/> Small Pox</td> <td><input type="checkbox"/> Pleurisy</td> </tr> <tr> <td><input type="checkbox"/> Chicken Pox</td> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Polio</td> </tr> <tr> <td><input type="checkbox"/> Tuberculosis</td> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Epilepsy</td> </tr> <tr> <td><input type="checkbox"/> Whooping cough</td> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Lumbago</td> </tr> <tr> <td><input type="checkbox"/> Mental disorders</td> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Heart disease</td> </tr> <tr> <td><input type="checkbox"/> Thyroid disorder</td> <td><input type="checkbox"/> Measles</td> <td><input type="checkbox"/> Eczema</td> </tr> </table> <p><b>Surgeries:</b></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Date</th> <th style="width: 70%;">Type and Reason for surgery</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p><b>Previous injuries/trauma</b> (please give type and date).</p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p><b>Medications:</b> (please list and reason for taking)</p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p><b>Supplements:</b> (please list and reason for taking)</p> <table style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p><b>Allergies:</b> _____          _____          _____          _____</p>	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Mumps	<input type="checkbox"/> Influenza	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Polio	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Whooping cough	<input type="checkbox"/> Cancer	<input type="checkbox"/> Lumbago	<input type="checkbox"/> Mental disorders	<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Measles	<input type="checkbox"/> Eczema	Date	Type and Reason for surgery	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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**Please check any of the following you have had in the past 6 months.**

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**MUSCULOSKELETAL**

- Low back pain
- Pain between shoulders
- Neck pain
- Arm pain
- Joint pain/stiffness
- Walking problems
- Difficulty chewing/clicking jaw
- General stiffness

**NERVOUS SYSTEM**

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold tingling extremities
- Stress
- Hearing difficulties

**GENERAL**

- Fatigue
- Allergies
- Headache
- Fever

**GASTRO-INTESTINAL**

- Poor Excessive Appetite
- Excessive thirst
- Frequent nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver problems
- Gall bladder problems
- Weight trouble
- Abdominal cramps
- Gas/bloating after meals
- Heartburn
- Black/bloody stools
- Colitis

**GENITO-URINARY**

- Bladder problems
- Painful/excessive urination
- Discolored urine

**CARDIOVASCULAR/RESPIRATORY**

- Chest pain
- Short breath
- Blood pressure problems
- Irregular heartbeat
- Heart problems
- Varicose veins
- Ankle swelling
- Lung problems/congestion
- Stroke

**EENT**

- Vision problems
- Dental problems
- Sore throat
- Earaches
- Stuffed nose

**MALE/FEMALE**

- Menstrual irregularities
- Menstrual cramps
- Vaginal pain/Infection
- Breast pain/lumps
- Prostate/sexual dysfunction
- Other\_\_\_\_\_

**VASCULAR**

- Nausea/Vomiting
  - Dizziness
  - Numbness on one side of face or body
  - Difficulty walking
  - Difficulty swallowing
  - Difficulty speaking
  - Fainting/light-headed
  - Double vision/Rapid eye movement
  - Neck or head pain like never before
-

**Informed Consent for Examination and Treatment**

I (we) hereby consent to the performance of examination and treatment on me or on \_\_\_\_\_, by the licensed doctors of chiropractic, massage therapists, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period \_\_\_\_\_.

\_\_\_\_\_  
Patient's Name (Print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship or authority if not signed  
By patient

\_\_\_\_\_  
Witness

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**CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT  
TREATMENT, PAYMENT AND/OR HEALTHCARE OPERATIONS**

“Protected health information” means information about you, including demographic information such as your address and phone, age, gender, etc., that may identify you and relates to your past, present, or future physical or mental health or condition and related healthcare services.

**In signing this document I consent to the use or disclosure of my protected health information by Lifestyle Chiropractic for the purpose of diagnosis or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of the clinic. I understand that the doctors of Lifestyle Chiropractic may refuse to diagnose or treat me if I do not consent to the use or disclosure of my protected health information for the above stated purposes.**

The “Notice of Privacy Practices” is a document that describes the type of uses and disclosures of your protected health information that will occur in your treatment, payment of your bills, and in the performance of healthcare operation of the clinic.

**In signing this document I acknowledge that I have been given a copy of the Notice of Privacy Practices and have been informed that I have the right to review the Notice prior to signing this document.**

**I understand that I have the right to request that the clinic restrict how my protected health information is used and/or disclosed to carry out treatment, payment and/or healthcare operations. I understand that the clinic is not required to agree to any restrictions that I have requested, but if the clinic agrees to a requested restriction, then the restriction is binding on the clinic.**

**I understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that such revocation shall not apply to actions already taken by the clinic based on this consent document.**

Lifestyle Chiropractic reserves the right to change the privacy practices described in the “Notice of Privacy Practices” document. Any revisions to the Notice will be made available to you at your request and will be posted in the reception area.

**I have read and understand the foregoing notice and my questions have been answered to my full satisfaction.**

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Signature of patient/legal representative

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date signed

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## OFFICE FINANCIAL POLICY

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Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care if you so desire.

1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed \$100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.
2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance must not exceed \$100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered.

IF you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Finance Counselor: \_\_\_\_\_ Date: \_\_\_\_\_

Front Desk: \_\_\_\_\_ Date: \_\_\_\_\_