CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

THE NEW ART OF CHIROPRACTIC

Dr. Erick J Lundgren, DC

7501 80th St S Suite 100, Cottage Grove, MN 55016

(651) 459-2225 www.thenewartofchiropractic.com

thenewartofchiropractic@gmail.com

Patient Name	**Last**	**First**	**M.I.**
Address:		**City, State, Zip Code:**	
Home Phone Number:	**Cell Phone Number:**	**Email Address:**	
Sex: Male ☐ Female ☐	**Age:**	**Date of Birth:**	**Social Security Number:**
Marital Status Single ☐ Married ☐ Widowed ☐ Divorced ☐			
Emergency Contact:	**Phone Number:**	**Relationship:**	
Employer:	**Occupation:**	**Business Phone Number:**	
Spouse's Name:	**Spouse's Employer:**	**Spouse's Business Phone Number:**	
Is Condition Related to Accident: Yes ☐ No ☐	**Type of Accident** Employment ☐ Auto ☐ Other ☐	**Date of Accident:**	
Who Referred You? Physician ☐ Friend ☐ Patient ☐ Name:	Or choose one: Internet ☐ Yellow Pages ☐ Insurance Co ☐ Facebook ☐		

******* IF PATIENT IS A MINOR, PLEASE FILL OUT PATIENT/GUARDIAN INFORMATION BELOW *******

Mother	**Cell Phone:**	**Business Phone:**
Father	**Cell Phone:**	**Business Phone:**

Please Initial:

____ **Treatment Authorization - I hereby authorize The New Art of Chiropractic or their designee(s) to treat my or the patient's conditions as they deem appropriate.**

____ **Assignment of Benefits - I hereby assign the authorized benefits and direct that payment under any insurance policy or health plan to be made directly to The New Art of Chiropractic for any services rendered to me by or on behalf of The New Art of Chiropractic.**

____ **Medicare Patients - I request that payment of authorized Medicare benefits be made either to me or on my behalf to The New Art of Chiropractic for any services furnished to me by that organization. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.**

____ **Records Release to Insurance Carrier(s) and Other Payers - I hereby authorize The New Art of Chiropractic to release to my insurance company, health plan, HMO, no-fault, and/or workers' compensation carrier, any information including my complete health record needed to determine benefits for services provided by or on behalf of The New Art of Chiropractic.**

____ **"I understand that I am financially responsible for charges not covered under my insurance policy."**

☐ ***By checking this box and typing my name below, I am electronically signing my application.***

FOR ALL OF THE ABOVE INFORMATION _____ _____

Signature **Today's Date**

Patient Health Questionnaire

ACN Group, Inc. Form PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

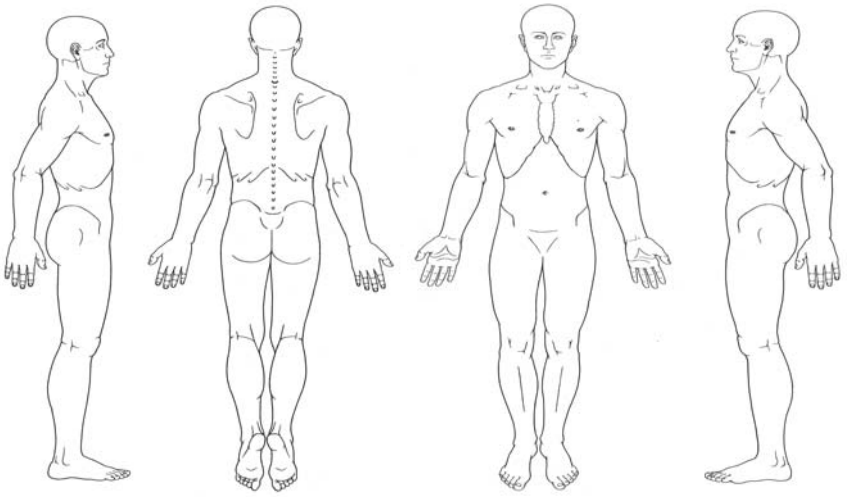
Patient Name _____ ***Date*** _____

1. When did your symptoms start: _____ ***Describe your symptoms and how they began:***

2. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

- ☐ Sharp ☐ Shooting
- ☐ Dull ache ☐ Burning
- ☐ Numb ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

5. How bad are your symptoms at their:

None *Unbearable*

a. worst: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

b. best: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪ *No complaints* ① ② *Mild, forgotten with activity* ③ ④ *Moderate, interferes with activity* ⑤ ⑥ *Limiting, prevents full activity* ⑦ ⑧ *Intense, preoccupied with seeking relief* ⑨ ⑩ *Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

☐ No One ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

☐ Xrays *date:* _____ ☐ CT Scan *date:* _____
☐ MRI *date:* _____ ☐ Other *date:* _____

10. Have you had similar symptoms in the past? ☐ Yes ☐ No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

☐ This Office ☐ Medical Doctor ☐ Other
☐ Other Chiropractor ☐ Physical Therapist

11. What is your occupation?

☐ Professional/Executive ☐ Laborer ☐ Retired
☐ White Collar/Secretarial ☐ Homemaker ☐ Other
☐ Tradesperson ☐ FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐ Full-time ☐ Self-employed ☐ Off work
☐ Part-time ☐ Unemployed ☐ Other

12. What do you hope to get from your visit/treatment *(select all that apply):*

☐ Reduce symptoms ☐ Explanation of condition/treatment ☐ How to prevent this from occurring again
☐ Resume/increase activity ☐ Learn how to take care of this on my own

Patient Signature _____ ***Date*** _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ☐None ☐Light ☐Moderate ☐Strenuous

What is your height and weight? Height ☐☐☐ (*Feet* *Inches*) Weight ☐☐☐ lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	*Present*	
☐	☐	Headaches
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Hip/Upper Leg Pain
☐	☐	Knee/Lower Leg Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Swelling/Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	General Fatigue
☐	☐	Muscular Incoordination
☐	☐	Visual Disturbances
☐	☐	Dizziness

Past	*Present*	
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Loss of Bladder Control
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Hepatitis
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinusitis

Past	*Present*	
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Use Tobacco Products
☐	☐	Drug/Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitis/Eczema/Rash
☐	☐	HIV/AIDS

Females Only

☐	☐	Birth Control Pills
☐	☐	Hormonal Replacement
☐	☐	Pregnancy

Other Health Problems/Issues

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

Doctors Signature _____ ***Date*** _____

Family Health History

Patient Name: _____ Today's Date: _____

Please review the below listed diseases and conditions and mark "C" for current health problems of a family member or "P" to indicate a past problem of a family member. Leave blank those spaces that do not apply.

Condition	Father Age___	Mother Age___	Spouse Age___	Brother(s) Age___ Age___		Sister(s) Age___ Age___		Children Age___ Age___ Age___		
Arthritis										
Asthma-Hay Fever										
Back Trouble										
Bursitis										
Cancer										
Diabetes										
Disc Problems										
Emotional Problems										
Headaches										
Heart Trouble										
High Blood Pressure										
Kidney Trouble										
Migraine										
Nervousness										
Neuritis										
Pinched Nerves										
Scoliosis										
Sinus Trouble										
Stomach Trouble										
Other:										

If any of the above family members are deceased, please list their age and cause of death

Authorization and Assignment

I authorize The New Art of Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint The New Art of Chiropractic authority necessary to endorse and cash my checks, drafts, or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charges directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand I will be charged a 1.25% monthly interest fee for all accounts over 30 days past due. I will also be responsible for any costs of collection, attorney's fee or court costs required to collect my bill. There will be a $20.00 charge for returned checks. The New Art of Chiropractic accepts cash, check, Visa, MasterCard, and Discover.

Informed Consent

I hereby authorize physicians and staff of The New Art of Chiropractic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of The New Art of Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care

Soreness – Chiropractic adjustments and therapy modalities are sometimes accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and therapy modalities. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

Soft Tissue Injury - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon, or other soft tissue injury.

Rib Injury – Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Therapy Burn – Heat generated by Therapy modalities may cause minor burns to the skin. This is rare, but if it occurs, you should report it to your doctor or a staff member.

Stroke – Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems – There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above Authorization and Assignment and Informed Consent, I hereby give my consent to have chiropractic treatment administered and authorize the assignment of payments. I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment.

☐ ***By checking this box and typing my name below, I am electronically signing my application.***

Patient, Parent, Guardian, or Personal Representative's Signature _____

Date _____ **Relationship to Patient** _____