THE LAKES
FAMILY CHIROPRACTIC

New Patient Intake

Date: _____ How did you hear about us?_____

Name: _____
Last First M.I

Date of Birth: _____ Age: _____ Gender M or F Email: _____

Address: _____ City: _____ State: _____

Zip: _____ Cell Phone: _____ Home Phone: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone #: _____Relation: _____

Payment Policies Agreement

I understand that I am responsible for any uncovered charges that the insurance doesn't pay for any reason. If I ask that insurance be billed, I understand and consider reasonable that the office will use the fee schedule and coding for chiropractors as generally determined by the State of Minnesota workers compensation rate; and I hereby assign my insurance company/Medicare or their intermediaries to pay The Lakes Family Chiropractic PLLC health care benefits directly at the business address, to bill insurance for each medical service performed, and assign Dr Adam Loe to release any administrative or medical information necessary to process insurance claims. I understand there is a $30 charge for returned checks.

Privacy Disclosure: This office conforms to the current HIPAA guidelines and policies for health information. A privacy policy is available at the front desk and may be requested if desired. I hereby authorize that my medical records may be forwarded to my other healthcare providers in the best interest of my healthcare or insurance payors in order to process claims information. I understand that Dr. Adam provides regular care in a semi-open, multi-patient treatment area format and that if I have specifically confidential information to share, I will request and be provided private room consultation. I understand that omission of information on this health history, my compliance with care, and providing Dr. Adam with accurate health condition updates will directly affect the ability of provider to come to proper diagnoses and provide safe and standard care and I agree to hold harmless Dr. Adam for any act of information omission on my part.

I hereby understand and agree to the privacy and payment policies and that the fee schedules are reasonable. I consent to chiropractic diagnostic and treatment procedures to be performed by Dr. Adam D. Loe, D.C.

Patient Signature (or guardian) _____ Date: _____

REASON FOR VISIT

Name: _____ **Date:** _____

What is the reason for your visit today? Please write down anything you want the doctor to know: _____

_____

_____

When did your symptoms start? _____ **Have you had these symptoms before?** Yes No

What caused your symptoms? _____

Is this an injury from work or is this a Worker's Compensation claim? Yes No

How often are you feeling your symptoms? (Circle one) Constantly Frequently Occasionally Rarely

Describe your symptoms: (Circle all applicable)

Dull Sharp Throbbing Burning Deep Aching Tingling Stabbing Cramping Numbness Radiating Stiffness

How are your symptoms progressing? Getting worse Not changing Getting Better

Today how severe are the symptoms on a scale of 1-10? (Circle) 1 2 3 4 5 6 7 8 9 10

Average in the past week, how severe have the symptoms been? 1 2 3 4 5 6 7 8 9 10

How much are your work or daily activities affected? Extremely Quite a bit Moderately Little bit None

Who else have you seen for these symptoms? Chiropractor MD-Physician Physical Therapist Masseuse
Other:_____

Do you consider your condition to be severe? Yes Yes, at times No

What makes it worse? _____ **What makes it better?** _____

What concerns you most about this problem? (Circle all applicable) Affecting Relationships Affecting Work

Could Be Serious Isn't Going Away Affecting Leisure Activities It's Getting Worse Affecting Sleep Other: _____

In general, how would you rate your current overall health? Excellent Very Good Good Fair Poor

When was your most recent chiropractic visit?

Year: _____ Reason: _____

When was your most recent spinal x-ray taken?

_____

Have you had any MRIs or CT scans taken? Yes No

Name of your Primary Care Physician:

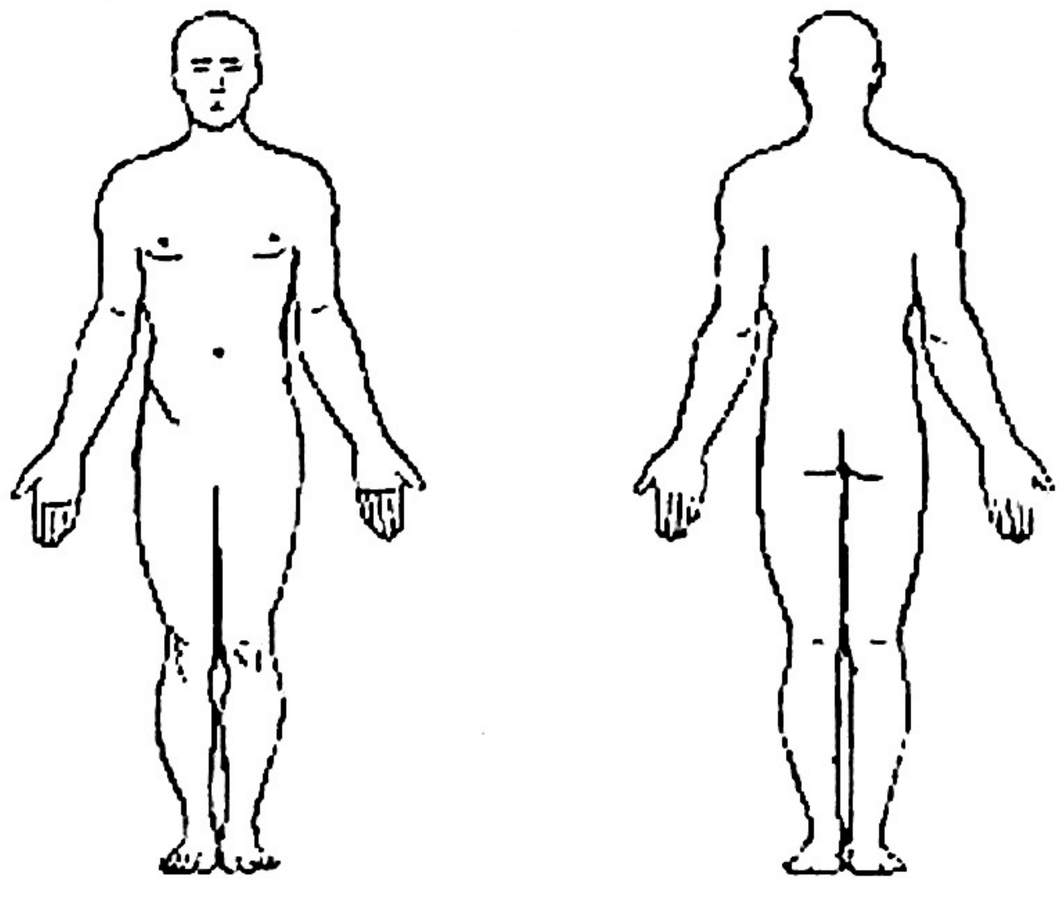
_____

Do you see any other providers regularly? (Circle)

Acupuncturist Personal Trainer Naturopath PT

Massage Therapist

Mark your problem areas on the picture below:



PATIENT HEALTH HISTORY

Name: _____ **Height:** _____ **Weight:**_____

What is your exercise routine? _____

*** In the next section, you will indicate whether these problems are past or current problems. Circle P if it is a past problem and circle C if it is a current problem. If it does not apply, leave it blank.**

Musculoskeletal & General

P C Degenerative Arthritis

P C Rheumatoid Arthritis or Gout

P C Compression Fracture

P C Osteomyelitis or Spondylitis

P C Osteoporosis

P C Psoriasis or psoriatic Arthritis

P C Fibromyalgia

Musculoskeletal Spine

P C Neck Problem

P C Mid-back Problem

P C Low-back Problem

P C Poor Posture or Scoliosis

P C Disc Injury/Herniation/Bulge

Nervous System

P C Muscle Weakness/Shaking

P C Tingling/Numbness

P C Pinched Nerve/Sciatica

P C Poor Balance

P C Depression

P C Anxiety

P C Dizziness/Vertigo

P C Seizures/Epilepsy

P C Vision Problems

P C Earache or Ear Infections

P C Jaw/TMJ or Mouth Problems

P C Chronic Sinus problems

P C Allergies

P C Sleeping Troubles

Musculoskeletal Extremity

P C Hip or Sacroiliac Issue L R

P C Leg or Knee Issue L R

P C Ankle or Foot L R

P C Shoulder Problem L R

P C Arm/Elbow/Hand Problem L R

P C Rib or Chest Pain

EENT

P C Asthma or Difficulty Breathing

P C Throat or Swallowing Problems

General Systems

P C Diabetes

P C High Blood Pressure

P C Recent Fever over 102 F

P C Thyroid Problem

P C Abdominal Pain

P C Constipation/Diarrhea

P C Heartburn/Acid Reflux/Ulcers

P C Leaky Bladder/Bowel

P C Inflammatory Bowel Disease

P C Menstrual Problems or PMS

P C Menopause Symptoms

P C Pregnancy Problems

P C Pacemaker or Implanted Device

P C History of Stroke or Aneurysm

P C Concerns about Weight

Injuries and General Constitution

P C Car Accident/Whiplash

P C Work or Sports Injury

P C Recent Fall or Accident

P C Smoking Habit

P C Alcohol/Drug Dependence

P C Unexplained Weight Loss

P C Cancer/Tumor

P C Blurred/Double Vision

P C Dizziness, Nausea, or Faintness when neck is moved

P C Medication Issue

Family History (Check all applicable)

☐ Chronic Neck/Back Problems
☐ Neck or Back Surgery
☐ Significant Arthritis
☐ Cancer
☐ Bone/Joint Problems
☐ Frequent Headaches or migraines

Please list all medications/vitamins:

_____
_____
_____
_____

Please list all surgeries/procedures:

_____
_____
_____
_____