ABOUT THE PATIENT

Plymouth Spine & Health Center 16795 Cty. Rd. 24, Ste. 120, Plymouth, MN 55447

Name _____ Today's Date_____ Birth date _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____Gender ❑ M ❑ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

E-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Emergency Contact _____ Phone # _____

Whom may we thank for referring you? _____

Name of Medical Doctor(s)_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Plymouth Spine to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?_____
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

_____

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctors have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

NOTES: _____

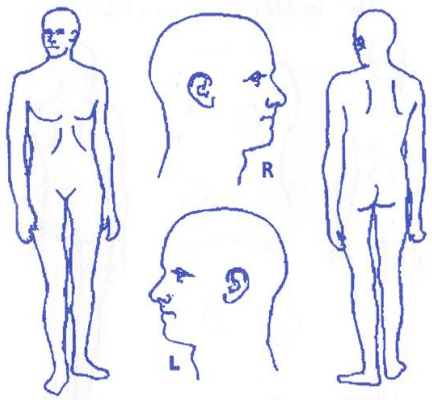
_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark *all* areas of concern.



GENERAL HEALTH HISTORY

Plymouth Spine & Health Center 16795 Cty. Rd. 24, Ste. 120, Plymouth, MN 55447

Patient Name_____

Mark the conditions that apply to you.

Past	Present		Past	Present	
❑	❑	Alcohol Use ___ Drinks/Week	❑	❑	High Blood Pressure
❑	❑	Anemia	❑	❑	High Cholesterol
❑	❑	Arthritis	❑	❑	HIV Positive
❑	❑	Asthma	❑	❑	Kidney Disease
❑	❑	Bulging Disc	❑	❑	Liver Disease
❑	❑	Cancer (Type_____)	❑	❑	Multiple Sclerosis
❑	❑	Depression	❑	❑	Osteoporosis
❑	❑	Diabetes	❑	❑	Pacemaker
❑	❑	Emphysema	❑	❑	Parkinson's Disease
❑	❑	Epilepsy	❑	❑	Pinched Nerve
❑	❑	Fibromyalgia	❑	❑	Prostate Problem
❑	❑	Gout	❑	❑	Prosthesis (Location_____)
❑	❑	Heart Disease	❑	❑	Rheumatoid Arthritis
❑	❑	Headaches ❑ / Migraines ❑	❑	❑	Stroke History
❑	❑	Hepatitis	❑	❑	Thyroid
❑	❑	Hernia	❑	❑	Other:_____
❑	❑	Herniated Disc	❑	❑	Other:_____

1. List any medications you are taking: _____

_____

2. Please list all doctors:_____

_____

3. Has any Doctor or other Professional Advised you to "Go to a Chiropractor"? ❑ No ❑ Yes, Name_____

_____

PAST HISTORY

4. List any past auto collisions: _____ **Was any care received?** _____

5. List any past work injuries: _____ **Was any care received?**_____

6. List any past sport, recreational, or home injuries: _____

7. Please describe any past conditions and treatments received:_____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____