SPINE AND SPORT CHIROPRACTIC
700 Western Ave Suite 200 Minot, ND 58701
701-838-2121 www.minotspineandsport.com
Dr. Andrea Burckhard

PATIENT INFORMATION

Please complete the following forms to the best of your knowledge. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help you.

Patient's Full Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Birth Date: _____ Gender: ___Female ___Male

Are You: ____Minor ____Single ____Married ____Separated ____Divorced ____Widowed

May we contact you via e-mail? ☐ Yes ☐ No

(Monthly Newsletters, Appt. Reminders, Updates, Schedule Changes)

E-Mail Address: _____

Your Employer: _____ Occupation: _____

Employer Address: _____City:_____State:_____ Zip: _____

Spouse's Name: _____Workplace:_____Work Phone_____

Mother's Name: _____Workplace:_____WorkPhone_____
(If a minor)

Father's Name: _____Workplace:_____Work Phone_____
(If a minor)

Emergency Contact: _____ Phone #:_____

Who can we thank for referring you to us? _____

Insurance Information

☐ **Check here if you currently have no insurance**

If we have taken a copy of your insurance card it is not necessary to fill out the insurance part of this form.

Insurance Company: _____Phone #:_____

Address: _____ City: _____ State: _____ Zip: _____

Name of Policy Holder: _____ Relationship To Patient: _____

Policy Number: _____ Group Number: _____

Thank you for choosing our practice for your chiropractic needs.

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Financial Policy

Welcome to Spine and Sport Chiropractic. We are excited to have you as a patient! We will do our best to confirm your eligibility and level of insurance coverage for chiropractic care.

- Ultimately, it is your responsibility to know your insurance benefits. Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services.
- Payment for non-covered services and co-payment amount are due on the day of service. A time of service discount is available on all chiropractic services. This discount does not apply to nutritional supplements or supplies.
- If you are unable to keep an appointment, we ask that you kindly provide us with at least eight hours notice. We ask for this advance notice so that we can offer the appointment to another patient.
- If you have any questions about your individual insurance or any of our financial policies, please ask. If you need to make special arrangements, please ask. **We will never deny care to anyone based solely on ability to pay.**

Date_____ Patient's Signature _____

Informed Consent

I hereby authorize physician(s) and staff at Spine and Sport Chiropractic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Chiropractic, as well as all other types of healthcare, 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.

Chiropractic is a system of healthcare delivery and therefore, as with any healthcare 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:

- **Temporary soreness or increased symptoms or pain.** It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.
- **Dizziness, nausea, flushing.** These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.
- **Fractures.** When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition; your treatment plan will be modified to minimize risk of fracture.
- **Disc herniation or prolapse.** Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.
- **Stroke**. A certain rare type of stroke has been associated with cervical manipulation. According to the literature, possible neurological complications can arise in 1 per 1-8 million office visits or 1 per 2-5.85 million adjustments. Screening tests are performed when necessary to rule out high-risk patients. Alternative spinal adjusting is utilized when necessary to minimize any potential risks.
- **Burns.** This is a rare complication that can occur from physiotherapy devices that produce heat.

If you have any question concerning this form or the above statements, please ask your doctor.
Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date: _____ Patient's Signature: _____

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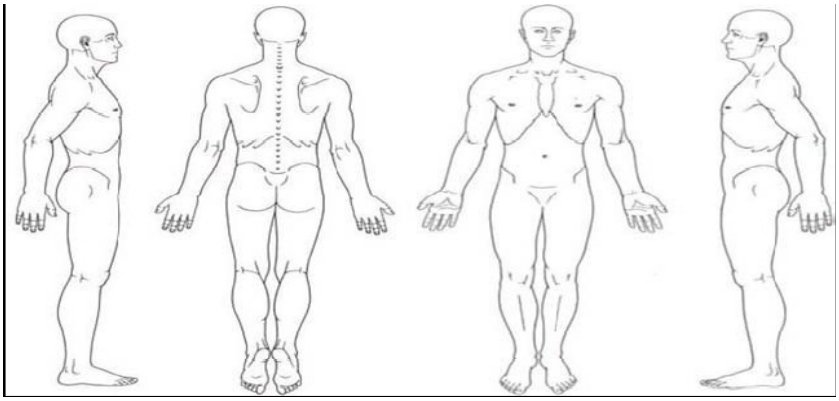
PATIENT HEALTH QUESTIONNAIRE

Patient Name _____ *Date* _____

1. ***Describe your symptom(s)*** _____
   a. When did your symptom(s) start? _____
   b. How did your symptom(s) begin? _____
   c. What makes your symptom(s) better/worse? _____

2. ***How often do you experience your symptoms?***
   [1] Constantly (76-100% of the day) [2] Frequently (51-75% of the day)
   [3] Occasionally (26-50% of the day) [4] Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. ***What describes the nature of your symptoms?***
   [1] Sharp [2] Dull Ache [3] Numb
   [4] Shooting [5] Burning [6] Tingling

4. ***How are your symptoms changing?***
   [1] Getting Better
   [2] Not Changing
   [3] Getting Worse

5. ***Average pain intensity:***
   Last 24 hours: **no pain** [0] [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] **unbearable pain**
   Past 4 weeks: **no pain** [0] [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] **unbearable pain**

6. ***During the <u>past 4 weeks</u> how much of the time has your condition interfered with your usual daily activities?***
   (Including both work outside the home and housework, etc.)
   [1] All of the time [2] Most of the time [3] Some of the time [4] Quite a bit [5] None of the time

7. ***In general would you say your overall health right now is…..***
   [1] Excellent [2] Very Good [3] Good [4] Fair [5] Poor

8. ***Who have you seen for your symptoms?*** [1] No One [2] Medical Doctor [3] Other
   [4] Other Chiropractor [5] Physical Therapist
   a. What treatment did you receive and when? _____
   b. What tests have you have for your symptoms and when were they performed? [1] X-rays *date*: _____ [2] CT scan *date*: _____ [3] MRI *date:* _____ [4] Other *date:* _____

9. ***Have you had similar symptoms in the past?*** [1] Yes [2] No
   a. If you have receive treatment in the past for the same or similar symptoms, who did you see? [1] This office [2] Other Chiropractor [3] Medical Doctor [4] Physical Therapist [5] Other

Patient Signature _____ **Date** _____

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PATIENT HEALTH QUESTIONNAIRE-2

Patient Name: _____ **Date:** _____

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

Height: _____Ft _____ In **Weight:** _____lbs

For each condition below check if you have had it in the past and/or in the present.

Past / Present		Past / Present		Past / Present	
☐	☐ Headache	☐	☐ High Blood Pressure	☐	☐ Diabetes
☐	☐ Neck Pain	☐	☐ Heart Attack	☐	☐ Excessive Thirst
☐	☐ Upper Back Pain	☐	☐ Chest Pain	☐	☐ Frequent Urination
☐	☐ Mid Back Pain	☐	☐ Stroke	☐	☐ Tobacco Use
☐	☐ Low Back Pain	☐	☐ Angina	☐	☐ Drug/Alcohol Dependence
☐	☐ Shoulder Pain	☐	☐ Kidney Stones	☐	☐ Allergies
☐	☐ Elbow/Upper Arm Pain	☐	☐ Kidney Disorder	☐	☐ Depression
☐	☐ Wrist Pain	☐	☐ Bladder Infection	☐	☐ Systemic Lupus
☐	☐ Hand Pain	☐	☐ Painful Urination	☐	☐ Epilepsy
☐	☐ Hip/Upper Leg Pain	☐	☐ Loss of Bladder Control	☐	☐ Dermatitis/Eczema/Rash
☐	☐ Knee/ Lower Leg Pain	☐	☐ Abdominal Pain	☐	☐ HIV/AIDS
☐	☐ Ankle/Foot Pain	☐	☐ Ulcer		**Other Health Problems**
☐	☐ Jaw Pain	☐	☐ Hepatitis	☐	☐
☐	☐ Joint Swelling/Stiffness	☐	☐ Liver/Bladder Disorder	☐	☐
☐	☐ Arthritis	☐	☐ Cancer		
☐	☐ Rheumatoid Arthritis	☐	☐ Tumor		**Females Only**
☐	☐ General Fatigue	☐	☐ Asthma	☐	☐ Birth Control
☐	☐ Muscle Un-coordination	☐	☐ Chronic Sinusitis	☐	☐ Hormone Replacement
☐	☐ Visual Disturbance			☐	☐ Pregnancy
☐	☐ Dizziness				

Indicate if an immediate family member has had any of the following:
☐Rheumatoid Arthritis ☐Heart Problems ☐Diabetes ☐Cancer ☐Lupus ☐ _____

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

_____

_____

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

_____

_____

Patient Signature: _____ **Date:** _____

Clinic Use Only

Doctor's Additional Comments: _____

_____

Doctor's Signature: _____ Date:_____

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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health information we encourage you to read the NOTICE OF PRIVACY PRACTICES (HIPAA) that is available in-office and on our website.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to use by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance company (or companies) require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. *Our office is not obligated to agree to those restrictions.*

3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Legal Representative
(e.g. Attorney-In-Fact, Guardian, Parent if a minor)

Relationship

Date Signed _____/ _____/ _____

Witness: _____