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, customized orthotics 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: _____ Signature of Parent or Guardian: _____

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FAMILY MEDICAL HISTORY

Please check if any blood relatives to the patient have/had any of the following illness and mark as follows:
M=Mother F=Father S=Sibling PGM=Paternal Grandmother MGM=Maternal Grandmother
PGF=Paternal Grandfather MGF=Maternal Grandfather

- ☐ Allergy, Asthma, or Eczema
- ☐ Cancer
- ☐ Diabetes or Low Blood Sugar
- ☐ Heart Trouble
- ☐ High Blood Pressure/Stroke
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Developmental Delay
- ☐ Mental Illness
- ☐ Scoliosis
- ☐ Ulcer
- ☐ Other_____

PREGNANCY

Please check any areas that applied to the patient's mother during her pregnancy:

- ☐ Complications
- ☐ Premature Contractions
- ☐ Attitude-Mostly Depressed
- ☐ Medications
- ☐ Excessive Weight Loss
- ☐ Attitude Mostly Happy
- ☐ Recreational Drugs
- ☐ Excessive Weight Gain
- ☐ Carried to Full Term
- ☐ Smoking
- ☐ Toxic Exposures
- ☐ Chiropractic Care
- ☐ Alcohol
- ☐ Allergic Reactions
- ☐ Hospitalization
- ☐ Caffeine
- ☐ Mental Trauma
- ☐ Any Diagnosed Illness
- ☐ Vitamins/Minerals
- ☐ Physical Injury
- ☐ Immunization
- ☐ Back Pain
- ☐ Prenatal Classes
- ☐ Bleeding
- ☐ Other Pain

LABOR & DELIVERY

- ☐ Greater than 12 Hours
- ☐ Complications
- ☐ Fetal Monitor Used
- ☐ Medications
- ☐ Forceps
- ☐ Caesarian
- ☐ Hospital
- ☐ Home Birth
- ☐ Premature Delivery
- ☐ Vacuum Extraction

PRENATAL HISTORY

Duration of Pregnancy: _____weeks. Birth Weight: _____lb_____oz Birth Length_____in
Apgar Score at Birth_____ Apgar Score at 5 minutes_____

Please check any problems the patient had at birth:

- ☐ Breathing
- ☐ Coloring
- ☐ Crying
- ☐ Choking
- ☐ Nursing
- ☐ Sleeping
- ☐ Jaundice
- ☐ Other_____

Please check if any item(s) applied to the patient at birth:

- ☐ Medication
- ☐ Artificial Feeding
- ☐ Vitamin K
- ☐ Surgery
- ☐ Erythromycin
- ☐ Circumcision
- ☐ Other_____

NUTRITION

Please check if the patient has received any of the following items:

- ☐ Breast Milk
- ☐ Commercial
- ☐ Cow's Milk
- ☐ Goat's Milk
- ☐ Other Milk
- ☐ Solid Foods
- ☐ Sweets
- ☐ Fruit Juice
- ☐ Vegetable Juice
- ☐ Vitamins
- ☐ Supplements
- ☐ Medications
- ☐ Other_____

_____ _____ _____
Patient's Name **Signature of Parent or Guardian** **Date**

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CHILD HEALTH QUESTIONNAIRE-1

GENERAL SYSTEM REVIEW

Has your child ever been unconscious or had a convulsion? [1] Yes [2] No
If yes, please explain:_____

Has your child had problems with the eyes, including vision? [1] Yes [2] No
If yes, please explain:_____

Has your child ever been cyanotic (turned blue)? [1] Yes [2] No
If yes, please explain _____

Does your child tolerate exercise? [1] Yes [2] No

Does your child have recurring problem with vomiting, diarrhea, constipation, or stomach pain? [1] Yes [2] No
If yes, please explain: _____

Do your child's stools look or smell abnormal? [1] Yes [2] No
If yes, please explain:_____

Does your child have any unusual problem on passing urine or any unusual frequency? [1] Yes [2] No
If yes, please explain: _____

Does your child have any unusual smell or appearance of urine? [1] Yes [2] No
If yes, please explain:_____

Does your child complain of an extremity or back pain? [1] Yes [2] No
If yes, please indicate where:_____

Do you notice a limp or unusual gait pattern when your child walks? [1] Yes [2] No
If yes, please explain:_____

Does your child have any allergies, eczema, hay fever, hives, asthma, or drug reactions? [1] Yes [2] No
If yes, please explain:_____

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CHILD HEALTH QUESTIONNAIRE-2

IMMUNIZATION
Please list any immunizations that the patient has received along with the date it was received and any reactions observed:
_____
_____

ILLNESSES
Please list any previous illnesses the patient has had along with the date:
_____
_____

FAMILY PHYSICIAN
Name of pediatrician and date of last exam:
_____

REASON FOR TODAY'S VISIT
Reason for visit:
_____

When did you notice your child's symptoms?
_____

Is this condition getting progressively worse? [1] Yes [2] No
If yes, please explain: _____

What treatment, if any, has the patient already received for this condition?
☐ Medication ☐ Surgery ☐Physical Therapy ☐ Other

Name and facility of the other doctor(s) who have treated the patient for this condition:
_____
_____
_____

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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: _____