Minneapolis & St. Paul Chiropractic

4401 East Lake Street
Minneapolis, MN 55406
(612) 724-4647
(612) 729-3606 fax

PATIENT INFORMATION FORM

Name: _____ Today's Date: ___/___/___

Social Security Number ☐☐☐☐☐☐☐☐☐ Birth Date: ___/___/___ Age: ____ Gender: F M

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street _____

City _____ State _____ Zip _____

List phone number(s) in order of preference for receiving appointment reminder and/or patient care calls:

1. Home / Cell / Work _____ 2. Home / Cell / Work _____

3. Home / Cell / Work _____ E-mail address _____
(We will not share your email address.)

How did you learn about us? _____

This authorization allows Minneapolis & St. Paul Chiropractic to discuss all aspects of my protected health information with the individual listed below

Name_____ Relationship_____ Phone number_____

Who should we contact in the event of an emergency? _____ Phone (_____) _____

Address of contact person _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (_____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Marital Status: □ Married □ Separated □ Widowed □ Single How many children? _____

Name of Spouse _____ Spouse's Date of Birth ___/___/___

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (_____) _____

Spouse is a student at _____ ☐ FULL-TIME ☐ PART-TIME

Do you have health insurance? ☐ YES ☐ NO Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ___/___/____

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/____

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HEALTH QUESTIONNAIRE

Name: _____
Date:

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): _____

_____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? _____

_____

Approximately, when did your injury or condition occur? ___/___/____

Describe your condition, symptoms, or the purpose of this appointment: _____

_____

Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe: _____

_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Name: _____ Type of Practice: _____ Date of Last Visit: ___/___/____

Date of last physical examination? _____

What operations have you had? _____ When? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: _____

What medications or drugs are you taking? _____

_____

Family History	**Age**	**Health Problems or cause of death**
Mother:		
Father:		
Mother's Mother:		
Mother's Father:		
Father's Mother:		
Father's Father:		
Brothers:		
Sisters:		
Children:		

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Name: _____
Date:

Please check the conditions you have or have had:

- ☐ AIDS or HIV+
- ☐ Anemia
- ☐ Arthritis
- ☐ Cancer
- ☐ Epilepsy
- ☐ Hypoglycemia
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Venereal Disease

SKIN HAIR NAILS

- ☐ Eczema
- ☐ Itchy skin
- ☐ Dry scalp
- ☐ Oily scalp
- ☐ Rough, scaly skin
- ☐ Dry skin
- ☐ Oily skin
- ☐ Psoriasis
- ☐ Yellow skin
- ☐ Bruise easily
- ☐ Paper thin nails
- ☐ Pale skin
- ☐ Nail biting
- ☐ Baldness

NOSE & SINUSES

- ☐ Unusual nasal discharge
- ☐ Nose bleeds
- ☐ Pressure over eyes
- ☐ Pressure under eyes
- ☐ Obstruction of nose
- ☐ Frequent colds
- ☐ Sinusitis
- ☐ Nasal allergies
- ☐ Loss of sense of smell
- ☐ Any trauma to nose

MOUTH AND THROAT

- ☐ Pain in mouth
- ☐ Pain in throat
- ☐ Bleeding gums
- ☐ Cavities
- ☐ Abscessed teeth
- ☐ Dentures
- ☐ Difficulty swallowing
- ☐ Changes in voice

RESPIRATORY

- ☐ Shortness of breath
- ☐ Can't breathe while lying down
- ☐ Can't sleep while lying down
- ☐ Dry cough
- ☐ Productive cough
- ☐ Coughing up blood
- ☐ Wheezing

EYES

- ☐ Blurring of vision
- ☐ Double vision
- ☐ Eyes fatigue easily
- ☐ Excessive tearing
- ☐ Lack of tearing
- ☐ Light bothers eyes
- ☐ Excessive itching
- ☐ Pain in eyeball

EARS

- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Discharge from ears
- ☐ Vertigo
- ☐ Ringing in ears

GASTROINTESTINAL

- ☐ Poor appetite
- ☐ Constant nibbling
- ☐ Difficulty in swallowing
- ☐ Indigestion
- ☐ Can't eat some foods
- ☐ Nausea & vomiting
- ☐ Jaundice
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids

GENITOURINARY

Urination is:

☐Frequent ☐Normal ☐Infrequent

The amount is:

☐High ☐Normal ☐Low

- ☐ Need to get up at night to urinate
- ☐ Abnormal desire to urinate
- ☐ Difficulty starting urination
- ☐ Decreased output
- ☐ Pain on urination
- ☐ Dribbling
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Lack of bladder control
- ☐ Abdominal pain

SOCIAL HISTORY

- ☐ Smoking
- ☐ Other tobacco use
- ☐ Alcohol use
- ☐ Drink coffee or tea
- ☐ Nervousness
- ☐ Irritability
- ☐ Fatigue
- ☐ Depression
- ☐ Generally feel run-down
- ☐ Crave salt
- ☐ Crave sweets

Diet is:

- ☐ Balanced
- ☐ Not Balanced

Rest is:

- ☐ Sufficient
- ☐ Not Sufficient

Recreation is:

- ☐ Sufficient
- ☐ Not Sufficient

My family stress is:

- ☐ Severe
- ☐ Moderate
- ☐ Minimal
- ☐ None

My job stress is:

- ☐ Severe
- ☐ Moderate
- ☐ Minimal
- ☐ None

How do you like your work?

- ☐ I like it very much
- ☐ It's ok
- ☐ I hate it

VENEREAL DISEASE

- ☐ AIDS
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Other

WOMEN ONLY

- ☐ Painful period
- ☐ Spotting
- ☐ Vaginal discharge
- ☐ Premenstrual symptoms
- ☐ Irregular periods
- ☐ Lumps in breast

# of Pregnancies _____.
# of Deliveries _____.

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Name: _____.
Date:

CARDIOVASCULAR

- ☐ General Swelling
- ☐ Swelling in legs
- ☐ Swelling in face
- ☐ Swelling around eyes
- ☐ Chest pain
- ☐ Pounding heart beat
- ☐ Heart "jumps"
- ☐ Rapid heart beat
- ☐ Rapid heart beat
- ☐ Blue or purple skin
- ☐ Blue or purple nail beds
- ☐ Fainting
- ☐ Hypertension

VERTEBROBASILAR

- ☐ Double Vision
- ☐ Loss of coordination
- ☐ Irregular muscle movement
- ☐ Ringing in ears
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Hardening of the arteries
- ☐ Areas of muscle weakness
- ☐ Dizziness with nausea
- ☐ Dizziness without nausea
- ☐ Blurred vision
- ☐ Fainting spells
- ☐ Stroke
- ☐ Diabetes
- ☐ Pain over the heart
- ☐ Cold hands and/or feet
- ☐ Areas of numbness
- ☐ Arthritis of the neck
- ☐ Previous neck or head injury
- ☐ Loss of memory
- ☐ Inability to form words (talk plainly)
- ☐ Periods of blindness in one eye
- ☐ Areas of abnormal sensation (burning, etc.)
- ☐ Areas of numbness
- ☐ Blood vessel disease (phlebitis, etc.)
- ☐ Check if you smoke
- ☐ Family members who have had a stroke
- ☐ Taking birth control pills

MUSCULOSKELETAL SYSTEM

HEAD

- ☐ Frequent headache
- ☐ Severe headache
- ☐ Head feels heavy
- ☐ Vertigo
- ☐ Light-headedness
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness

MID BACK

- ☐ Mid back pain
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing pain
- ☐ Dull ache
- ☐ Pain from front to back
- ☐ Pain over kidney area
- ☐ Muscle spasms in mid back

LOW BACK

- ☐ Low back pain
- ☐ Low back feels out of place
- ☐ Muscle spasms in low back

NECK

- ☐ Pain in neck
- ☐ Neck pain with movement
- ☐ Swelling in neck
- ☐ Stiff neck
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Limited neck movement

HIPS, LEGS, & FEET

- ☐ Pain in buttocks
- ☐ Pain down leg
- ☐ Knee pain
- ☐ Leg cramps
- ☐ Pins & needles in legs
- ☐ Numbness in leg
- ☐ Numbness in toes
- ☐ Cold feet
- ☐ Swollen ankles
- ☐ Swollen feet
- ☐ Hip Pain

SHOULDERS ARMS & HANDS

- ☐ Pain in shoulders (R-L)
- ☐ Pain across shoulders
- ☐ Tension in shoulders
- ☐ Muscle spasms in shoulder
- ☐ Can't raise arm
  - ☐ Above Shoulder level
  - ☐ Over Head
- ☐ Pain in upper arm
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins & needles
  - ☐ In arms
  - ☐ In fingers
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Loss of grip strength

Height: _____
Weight: _____
Shoe Size: _____ **Nar Reg Wide**