



North Maple Grove Chiropractic

John W Petersen DC

9505 Blackoaks Lane No.

Maple Grove MN 55311

Phone 763-4420-4111

Fax 763-420-4145

Confidential Patient Information

Welcome to our Chiropractic Office!

Date_____

Patient's Full Name_____

Address_____

City - State - Zip code_____

Date of Birth_____ Age_____ Gender: Male Female

Phone: Home_____ Work_____ Cell_____

Email address_____

Social Security Number_____

Height_____ Weight_____ Marital Status_____

Occupation_____

Employer Name_____

Employer Address_____

Name and Address of Nearest Living Relative not living with you_____

Name / Address of your Primary Care Physician_____

It is our policy to send a summary of findings to your doctor, in order to better coordinate your health care.

Who may we thank for referring you to our practice?_____



Dr. John Petersen
North Maple Grove Chiropractic

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PATIENT NAME _____

DATE _____

Is illness or injury related to: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other	Do you have other insurance that might cover this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list other insurance company name:	
Please list your reason(s) for this visit or your condition(s) in order of importance: 1 _____ 2 _____ 3 _____ 4 _____	Date you first noticed: _____ _____ _____ _____	Using a scale in which "0" is <u>none</u> (no pain or symptoms) and "10" is <u>severe</u> pain or symptom(s), circle the number that best reflects your condition: ↓ none to severe ↓	Please check the box below that best represents how much of the time you feel pain or your symptom(s) for the listed reason:
		0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
		0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
		0 1 2 3 4 5 6 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%

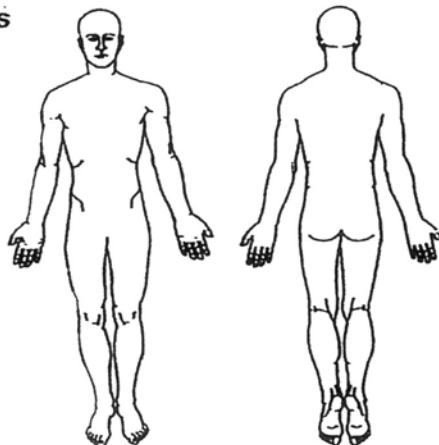
For each of the reasons or conditions listed above, please mark how it happened:

- Developed over time Illness Injury Auto accident Other _____ I don't know
- Developed over time Illness Injury Auto accident Other _____ I don't know
- Developed over time Illness Injury Auto accident Other _____ I don't know
- Developed over time Illness Injury Auto accident Other _____ I don't know

For each reason listed above, please check if it is better or worse with any of the following:

	HEAT		COLD		REST		ACTIVITY		OTHER (please describe on line below)		
	better	worse	better	worse	better	worse	better	worse	better	worse	
Reason 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reason 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reason 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reason 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:



- +++ Sharp or stabbing
- ooo Pins and needles
- vvv Dull or aching
- /// Numbness

Please check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	Normal	Somewhat limited	Severely limited
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resting in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer work/typing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Normal work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (list below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Chiropractic Patient Information Form

Please continue ...

- a. During what time of the day do you feel worse? _____
- b. Do you sleep well? Yes No What are your normal sleeping hours? _____ to _____
- c. Are you currently under the care of a medical doctor or other type of health care provider for any condition?
 No Yes → For what condition? _____
Name of doctor/provider _____ Phone number _____
- d. Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
 No Yes If yes, please describe each event below:
Event _____ Year _____
Event _____ Year _____
- e. Do you exercise? Yes No If yes, please describe activity _____
How many days a week? _____ How many minutes per session? _____

Personal history

The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

- Pain in body**
- | | | |
|---|---|--|
| <input type="checkbox"/> Neck pain with difficulty swallowing | <input type="checkbox"/> Recent progressive muscle weakness or shaking | <input type="checkbox"/> Severe degenerative arthritis |
| <input type="checkbox"/> Extreme neck stiffness with pain or electric shocks in arms or legs when moving neck | <input type="checkbox"/> Recent or current fever over 102°F | <input type="checkbox"/> History of compression fracture |
| <input type="checkbox"/> Leg pain that worsens with exercise but is relieved by resting | <input type="checkbox"/> Loss of bowel or bladder control | <input type="checkbox"/> History of heart attack |
| <input type="checkbox"/> Loss of feeling in inner thighs | <input type="checkbox"/> Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions | <input type="checkbox"/> History of stroke or aneurysm |
| <input type="checkbox"/> Back pain with urinary problems | <input type="checkbox"/> Recent major accident such as a fall from height, whiplash or blow to the head | <input type="checkbox"/> Past history of cancer or currently diagnosed with cancer |
- Types of pain**
- | | | |
|---|--|---|
| <input type="checkbox"/> Severe pain interrupts sleep | <input type="checkbox"/> Memory loss after injury | <input type="checkbox"/> Diabetes with cold, burning or numb feet |
| <input type="checkbox"/> Constant pain that doesn't improve by changing positions or lying down | Previously diagnosed condition/ medical history | <input type="checkbox"/> Gout |
| | <input type="checkbox"/> Congenital bone or joint disorder | <input type="checkbox"/> Lupus |
| | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Ankylosing spondylitis |
| | | <input type="checkbox"/> Immune suppression such as from chemotherapy, organ transplant, etc. |
- Current conditions**
- | | | |
|---|--|--|
| <input type="checkbox"/> Unable to balance when walking | | <input type="checkbox"/> 3 or more months use of steroid medications or intravenous drugs (past or recent) |
| <input type="checkbox"/> Recent unexplained weight loss | | |

Family history

<input type="checkbox"/> Autoimmune disorders	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Seizure disorder

I certify that the above information is true and correct to the best of my knowledge and I hereby consent to the release of my confidential medical and patient information in the possession of the practitioner named above to other health professionals to whom I am referred and to the insurance company or other entity responsible for payment, utilization and/or quality review for all or a portion of my care.

Signature _____ Today's date: ____/____/____

If patient required assistance to complete, sign name and state relationship (i.e., parent, translator) below:

Name _____ Relationship _____ Today's date: ____/____/____



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RECORDS RELEASE

I authorize the release of my records/x-rays or copies of such to the office of NORTH MAPLE GROVE CHIROPRACTIC, 9505 Blackoaks Lane N, Maple Grove, MN 55311.

This records release is valid for one year from the date of my signature.

PRINTED NAME OF PATIENT: _____

NAME OF PARENT OR GUARDIAN: _____

PATIENT SIGNATURE: _____ DATE: _____

PATIENT SS#: _____ PATIENT DATE OF BIRTH _____

STANDARD CONSENT FORM

Any procedure intended to help may also do harm. While chiropractic procedures done in this office are usually considered remarkably safe and effective, please understand there are occasional and rare complications which have been documented. While the chances of experiencing these complications are extremely small, it is the practice of this office to fully inform and educate all of our patients about them. Cervical manipulations have rarely caused injuries to the small blood vessels that go to and from the upper neck to the brain. The risk of this occurring is thought to be one in three million to one in fourteen million, according to several studies. These other complications include but are not limited to:

pain	burns	swelling	sensory changes
soft tissue injury	bruising	bleeding	stroke(CVA)
discoloration	fracture	dizziness	inflammation
disc injury	nausea	weakness	soreness

By signing this I understand that there is no guarantee or warranty of a specific cure or result. I understand that I can request specific additional information from the doctor regarding treatment risk. Given this information, I consent to care.

PATIENT SIGNATURE: _____ DATE: _____

GUARDIAN SIGNATURE _____ DATE _____

INSURANCE INFORMATION

Your insurance is an agreement between you and your insurance company. Some insurance plans have limited benefits, which we cannot know in advance. Our office will go to extreme lengths to make sure you get your maximum benefit from your insurance. If all of our efforts fail, you may be responsible for some visit charges.

PATIENT 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 HIPPA NOTICE that is available to you at the front desk before signing this consent.

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 us 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 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 effect the use of those records for the care given prior to the 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 this 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 Patient

Date

Dr. John Petersen

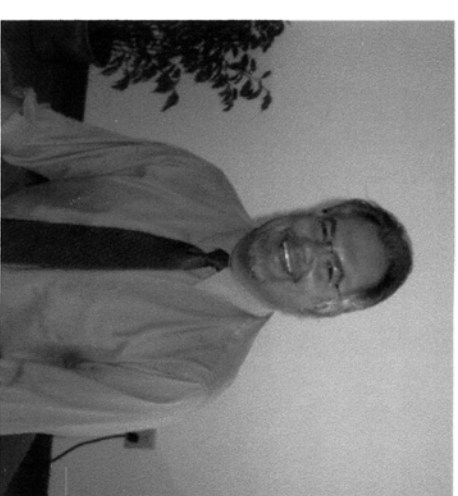
Dr. Petersen attended St. John's University and Northwestern College of Chiropractic. He was in private practice for 18 years in New Hope prior to moving to the Maple Grove area.

Dr. Petersen participated in a specialty program in Neurology, he obtained his Diplomate in Chiropractic Neurology through New York College of Chiropractic.

The office treats patients of all ages, little leaguers to seniors. His specialty includes treatment of car accident patients.

Dr. Petersen accepts referrals from medical physicians, attorneys, and all major insurance companies. The office is a Top Tier provider for:

Medica
Health Partners
Preferred One
Blue Cross/Blue Shield
Choice Plus
Aetna plans
United Health Care
Medicare
Medical Assistance
U Care
Union Plans



Most plans today DO NOT require a medical referral.

" Call our office today for an appointment. Back pain, neck pain and headaches can be due to chiropractic problems. I will gladly work with your physician. If you are frustrated with these conditions, call our office for a chiropractic exam."