

# ABOUT THE PATIENT

HealthStar Chiropractic Center  
7525 Mitchell Road, Suite 300, Eden Prairie, MN 55344

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Ph. \_\_\_\_\_ Cell Ph. \_\_\_\_\_ Referred by \_\_\_\_\_ 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 \_\_\_\_\_ Ph # \_\_\_\_\_  
 Name of Medical Doctor(s) \_\_\_\_\_ Name of Ins. Co. \_\_\_\_\_

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize the release of any medical or other information needed to process my insurance claim.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits to the provider for services shown on the insurance form.
- Person responsible for this account if other than the patient? \_\_\_\_\_
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- 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 the 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 the 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 the evening  Pain radiates to \_\_\_\_\_
4. If you have been living with this problem for longer than 1 month, why are you now seeking care? \_\_\_\_\_
5. What does your condition affect most in your life? \_\_\_\_\_
6. What makes you feel better? \_\_\_\_\_
7. What makes you feel worse? \_\_\_\_\_
8. What Doctor's have you seen for this? \_\_\_\_\_
9. Type of treatment: \_\_\_\_\_
10. Results: \_\_\_\_\_
11. Are you happy with your Overall Health?  Yes  No

NOTES: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

