ABOUT THE PATIENT

Alpha Spine Health & Injury Center Lakeville, MN 55044

Name _____ **Today's Date**_____ **Birthdate** _____ **Age**_____

Address _____ **City** _____**State** _____ **Zip** _____

Phone _____ **Work Phone** _____ **Gender** ❑ **M** ❑ **F**

Type of Work _____ **Your Employer** _____

How did you hear about us? _____ **If referred, who can we thank?** _____

E-mail Address _____ **Have you been to a chiropractor before?** □ **Yes** □ **No**

Emergency Contact _____ **Phone** _____

- **I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.**
- **I authorize Alpha Spine Health & Injury Center to release and / or request records to or from other providers as may be necessary.**
- **I understand I am responsible for all bills incurred in this office.**
- **I authorize assignment of my insurance benefits (if applicable) directly to the provider.**
- **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. _____ **Pain Scale 0-10** _____ **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 evening ❑ Pain radiates to_____

2. _____ **Pain Scale 0-10** _____ **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 evening ❑ Pain radiates to_____

3. _____ **Pain Scale 0-10** _____ **How long has this been an issue?** _____

Is it: ❑ Dull ❑ Sharp ❑ Achey ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

Are you Pregnant? ❑ Yes ❑ No

5. What makes it feel better? _____

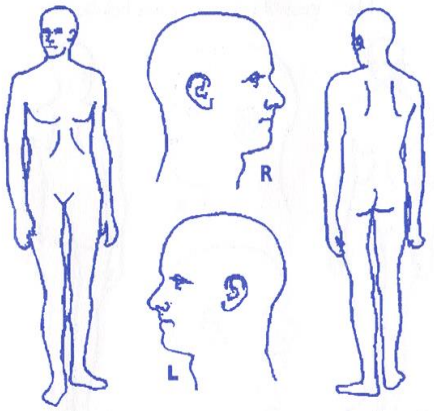
6. What makes it feel worse? _____

7. What Doctor's / Treatment have you seen for this? _____

_____

8. Results: _____

Please mark all areas of concern below



PAST HISTORY

1. List any past auto collisions_____

2. List any past work injuries_____

3. Please list any relevant hospitalizations / surgeries / conditions / treatments

_____

GENERAL HEALTH HISTORY

Alpha Spine Health & Injury Center Lakeville, MN 55044

Patient Name_____ ***Mark the conditions that apply to you.***

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Heart Pacemaker
❑	❑	Shortness of Breath	❑	❑	Chest Pains
❑	❑	Allergies / Asthma	❑	❑	Heart Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner Use
❑	❑	Hands or Feet Cold	❑	❑	HIV Positive
❑	❑	Muscle Aches	❑	❑	Cancer
❑	❑	Kidney Problems	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Liver Disease
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gallbladder Trouble	❑	❑	Stroke History
❑	❑	Tension / Irritability	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Osteoporosis / Osteomalacia
❑	❑	Tobacco Use	❑	❑	Other _____

1. List any medications you are taking: _____

2. Family Doctor's Name & Clinic Name: _____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Back/Neck Problems Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Back/Neck Problems Other_____

Is there any other family history you want us to know? _____

_____