NORTH SUBURBAN HEALTHCARE, P.A.
8770 Springbrook Dr NW Suite 100
Coon Rapids, MN 55433
Ted Harrison DC, FACO, CCST

Minor Patient Intake

Name_____ Date_____
First MI Last

Home Address _____
Street City State Zip

Phone _____ _____ _____
Cell Home Work

☐**Check here to receive text appointment reminders**. Text reminders are sent at approximately 5:00 pm the day before your appointment. **Appointment reminders are subject to your carrier's normal text messaging rates.** Reminders available for: AT&T, Boost Mobile, Cricket, MetroPCS, Nextel, Sprint, T-Mobile, US Cellular, Verizon, and Virgin Mobile.

☐ **Check here to receive e-mail appointment reminders.** E-mail reminders are sent approximately 2 hours before your scheduled appointment. Text and/or e-mail reminders may not be activated immediately.

E-Mail_____

Gender ☐M ☐F Date of Birth_____

Marital Status ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

If Married, Spouse's Name_____

Children ☐Y ☐N If yes, age of children_____

In the event of an emergency, please contact:

Name	Relationship	Phone Number

Employment Information

Employer_____

Employer's Address _____
Street City State Zip

Nature of Work_____

Authorizations

Persons you authorize the release of your health information to: Initial here if none _____

Name _____ Relationship _____ Initials _____

Name _____ Relationship _____ Initials _____

Authorization for the release of health information can be cancelled at any time by submitting cancellation in writing.

I understand that I am responsible for all charges incurred at North Suburban Healthcare, P.A., including any collection cost or attorney fees required to collect outstanding balances. Accounts greater than 60 days past due will be charged interest at a rate of 1% per month.

Signature_____ Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____

Patient Health Questionnaire I

Name_____ Date_____

Describe your symptoms_____

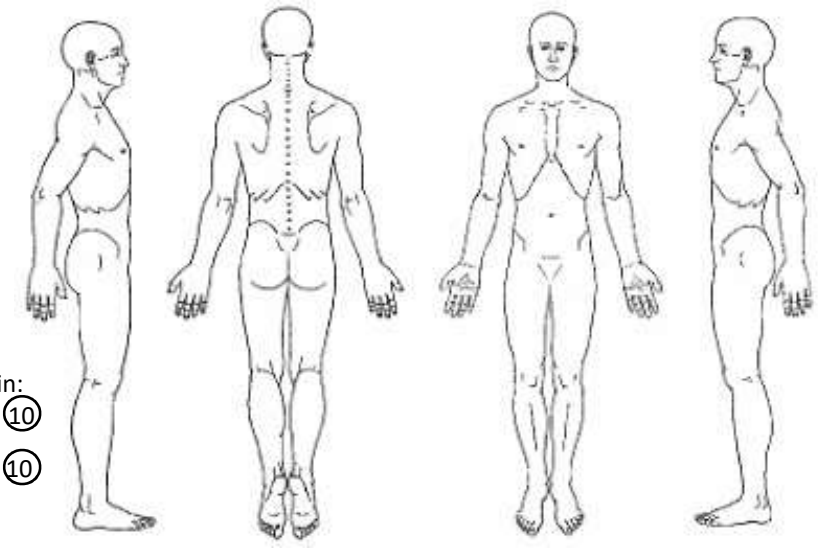
_____

When did the symptoms begin? (mm/dd/yy if possible) _____

How did the symptoms begin? _____

_____

Please indicate on the diagram where you are experiencing symptoms; Mark as:
S=Sharp D=Dull A=Aching N=Numbness T=Throbbing W=Weak O=Other



Description:
☐Sharp
☐Dull
☐Ache
☐Numb
☐Throbbing
☐Weak
☐Other: _____

Frequency:
☐Constant (76-100%)
☐Frequent (51-75%)
☐Occasional (26-50%)
☐ Intermittent (25% or less)

Average Pain intensity 0=No Pain and 10=Unbearable Pain:
Last 24 Hours: (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
Past Week: (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Are your symptoms affecting your ability to be active?
☐No effect
☐Some physical restrictions (light duty tasks only)
☐Need limited assistance with everyday tasks
☐Need assistance often
☐Significant inability to function without assistance
☐Am totally disabled/impaired

Your Symptoms Are: ☐Decreasing ☐Not Changing ☐Getting Worse
Symptoms Are Worse: ☐Morning ☐Afternoon ☐Night ☐Increases During Day ☐Same All Day
What makes symptoms better? ☐Nothing ☐Lying Down ☐Walking ☐Standing ☐Sitting ☐Movement/Exercise ☐Inactivity
What makes symptoms worse? ☐Nothing ☐Lying Down ☐Walking ☐Standing ☐Sitting ☐Movement/Exercise ☐Inactivity

Have you been treated for *this* episode? ☐Y ☐N If so, by whom? ☐Chiropractor ☐MD ☐Physical Therapist
☐Other_____ When?_____
What treatment did you receive?_____

Have you been treated for something similar in the past? ☐Y ☐N If so, by whom? ☐Chiropractor ☐MD ☐Physical Therapist
☐Other_____ When?_____
What treatment did you receive?_____

What is your current work status, if employed? ☐FT ☐PT ☐Other _____
Physical activity at work: ☐Sitting more than 50% of the time ☐Light manual labor ☐Heavy manual labor ☐Repeated motion
Has your work status changed because of current symptoms? ☐Y ☐N If so, how? _____

Signature_____ Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____

Patient Health Questionnaire II

Name_____ Date_____

If you have ever had a listed condition in the past, please check it in the Past column. If you are presently troubled by a condition, check it in the Present column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

Past	Present	
☐	☐	Neck Pain
☐	☐	Shoulder Pain
☐	☐	Upper Arm or Elbow Pain
☐	☐	Hand Pain
☐	☐	Wrist Pain
☐	☐	Upper Back Pain
☐	☐	Lower Back Pain
☐	☐	Upper Leg or Hip Pain
☐	☐	Lower Leg or Knee Pain
☐	☐	Ankle or Foot Pain
☐	☐	Jaw Pain
☐	☐	Swelling/Stiffness of Joint(s)
☐	☐	Fainting
☐	☐	Visual Disturbances
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Headache
☐	☐	Muscular Incoordination
☐	☐	Tinnitus (Noises in Ear)
☐	☐	Rapid Heart Beat
☐	☐	Chest Pains
☐	☐	Loss of Appetite
☐	☐	Anorexia
☐	☐	Abnormal Weight ☐Gain ☐ Loss
☐	☐	Excessive Thirst
☐	☐	Chronic Cough
☐	☐	Chronic Sinusitis
☐	☐	General Fatigue
☐	☐	Loss of Bladder Control
☐	☐	Painful Urination
☐	☐	Frequent Urination
☐	☐	Abdominal Pain
☐	☐	Constipation/Irregular bowel habits
☐	☐	Difficulty Swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Dermatitis/Eczema/Rash
☐	☐	Depression
☐	☐	Alcohol/Drug Dependence
☐	☐	Caffeine
How Much/Often? _____		
☐	☐	Tobacco
How Much/Often? _____		
☐	☐	Alcohol
How Much/Often? _____		

Past	Present	
☐	☐	Aortic Aneurysm
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Prostate Problems
☐	☐	Blood Disorder
☐	☐	Emphysema
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Ulcer
☐	☐	Liver/Gallbladder problems
☐	☐	Kidney Stones
☐	☐	Hepatitis
☐	☐	Bladder Infection
☐	☐	Kidney Disorders
☐	☐	Colitis
☐	☐	Irritable Colon
☐	☐	HIV/AIDS
☐	☐	Systemic Lupus
☐	☐	Other_____

For Females: Date of last menstrual period _____

☐	☐	Pregnancies How Many? _____ Currently? ☐ Yes ☐ No ☐ Unsure
☐	☐	Birth Control Pills/IUD/Implant/Other_____
☐	☐	Hormonal/Estrogen Replacement
☐	☐	PMS
☐	☐	Profuse Menstrual Flow
☐	☐	Irregular Menstrual Flow
☐	☐	Endometriosis
☐	☐	Breast Soreness/Lumps

Please indicate if a family member has had any of the following conditions:

- ☐ Cancer
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ High Blood Pressure
- ☐ Epilepsy
- ☐ Chronic Back Problems
- ☐ Chronic Headaches
- ☐ Lupus
- ☐ Other _____

Current:

Height _____ (ft/in)

Weight _____ (lbs.)

Please list any hospitalizations or surgical procedures:_____

_____

Please list any medications and/or supplements you are currently taking: _____

_____

Is there anything else you wish your doctor to know? _____

_____

Signature_____ Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____

Doctor's Comments_____

_____

_____

_____

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Patient Protected Health Information Consent

We want you to know how your Protected Health Information (PHI) is going to be used in this office, along with your rights concerning those records. Before we will begin any health care operations, we require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient (and/or their legal guardian) understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health, Auto, or Worker's Compensation 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 necessary for what the insurance companies require for payment.
2. The patient has a right to examine and obtain a patient copy of his or her own health records at any time and to request corrections. The patient may request to know what disclosures have been made and to 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 at 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 care given prior to the written request for revocation, but would apply to any care given after the written request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy. 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. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, we have the right to refuse to provide care.

I, the undersigned, have read and understand these consents and I agree to these policies and procedures.

Printed Name_____

Signature_____ Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____

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Insurance Authorization and Release of Records

I. I authorize payments of benefits and the release of any necessary medical information to process my claims with North Suburban Healthcare, P.A. I also request payment of government benefits to myself or to North Suburban Healthcare, P.A. located at 8770 Springbrook Drive Northwest, Suite 100, Coon Rapids, MN 55433.

II. I understand that an insurance policy is an agreement between my insurance carrier and myself, and that I am responsible for any and all charges incurred at North Suburban Healthcare, P.A., including deductible, coinsurance, and co-payment fees, and any collection costs and/or attorney's fees required to collect outstanding balances. Accounts greater than 60 days past due will be charged at an interest rate of 1% per month.

Subscriber on Policy _____
(The subscriber of the policy is the main policyholder)

Subscriber's Date of Birth _____

Subscriber's Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Other: _____

Print Patient's Name_____

Signature_____ Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____

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*If this information is not immediately available, please be aware that it must be provided as soon as possible so that we may bill your insurance. You will be billed directly until we receive this information.

Motor Vehicle Collision Claims*:

Insurance Company: _____ Claim Number: _____

Adjuster: _____ Adjuster's Phone Number: _____

Worker's Compensation Claims*:

Insurance Company: _____ Claim Number: _____

Adjuster: _____ Adjuster's Phone Number: _____

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Consent to Treatment of a Minor

I, (parent/guardian) _____ hereby request and authorize the doctors and other staff members of North Suburban Healthcare, P.A. permission to examine, x-ray, and treat my minor child:

Name _____

Date of Birth _____

By signing below, I attest that as of this date I have the legal right to select and authorize health care services for the minor child named above. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature of parent/guardian_____ Date_____

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Patient Rights and Responsibilities

Each patient at North Suburban Healthcare has the right to:

- Considerate, respectful, and impartial care in a safe setting.
- Reasonable access to care with effective communication, including the ability to have support persons present and the ability to receive assistance with physical limitations.
- Make informed decisions in advance of and during care, be involved in care planning & treatment, and to be informed of both expected and possible unanticipated outcomes of care.
- Be able to refuse care and receive information regarding the possible consequences of refusal.
- Expect all communications and records to be private and confidential, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law.
- Access to information contained in his/her personal clinical records within a reasonable timeframe upon written request and authorization.
- Be informed of charges for services and payment methods available.
- Freely voice complaints without being subject to discrimination, coercion, or reprisal, and to receive a prompt review of and resolution to a complaint.
- Receive a copy of these Patient Rights & Responsibilities. These shall also be posted in patient areas that are easily accessible for review by the public.

Each patient and/or guardian at North Suburban Healthcare is responsible for:

- Providing, to the best of his/her knowledge, accurate and complete information about matters relating to the patient's health
- Following the treatment plan as discussed and agreed with the health care provider
- The patient's actions and outcomes if he/she refuses treatment or fails to follow the care plan
- Being considerate and respectful of staff and other patient's persons, property, and this facility
- Providing all needed information for insurance processing and for ensuring that the financial obligations of his/her care is fulfilled
- Asking questions when he/she does not understand the information given
- Reporting episodes of pain and the effectiveness or lack of response to treatment
- Reporting perceived risks and/or unexpected change in condition during the course of care
- Following all facility rules and regulations.

Following these guidelines helps us ensure you receive the best care available.
All staff is educated annually regarding Patient's Rights & Responsibilities, and copies of this information is available to all staff.

Thank you for your cooperation.

By signing below, I hereby acknowledge that I have read and understand these Rights and Responsibilities.

Signature_____ Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____

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Informed Consent

Patient Name: _____ Date:_____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

Please initial each section as you understand it.

_____ The nature of the chiropractic adjustment

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. The doctors in this clinic will use that procedure to treat you. They may use their hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you may have experienced when you "crack" your knuckles. You may feel a sense of movement.

_____ Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

Spinal manipulative therapy, Palpation, Vital signs, Range of motion testing, Orthopedic testing, Basic neurological testing, Muscle strength testing, Postural analysis testing, Radiographic studies, Therapeutic exercises, Manual muscle stimulation, Inter-segmental traction therapy, Ultrasound, Hot/cold therapies, EMS, and other procedures as your doctor may deem necessary in their best professional judgement.

You have the right to refuse any of these procedures at time of treatment.

You may request another staff member to be present at any time during your appointment.

_____ The risks inherent in chiropractic adjustment & the probability of those risks occurring

As with any healthcare procedure, there are certain complications that may arise during chiropractic manipulation and therapy. The complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the doctor's attention it is your responsibility to inform the doctor.

Fractures are rare occurrences and generally result from an underlying weakness of the bone which we check for during the taking of your history and through the examination. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on this topic is inconclusive as to a specific incident of this complication occurring. If there is a casual relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of an arterial stroke.

_____ **The availability & nature of other treatment options, and the risks & dangers of remaining untreated**

Other treatment options for your condition may include self-administered, over the counter analgesics and rest; medical care and prescription drugs such as muscle relaxants; hospitalization; surgery. If you choose one of the "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

By signing below, you state that you understand the above explanation of the chiropractic adjustment and related treatment. You have weighed the risks involved in undergoing treatment and have decided that it is in your best interest to undergo the treatment recommended.

Signature_____ Date_____

Relationship to patient, if not self:_____ Reason unable to Sign_____