True North Chiropractic Center, LLC
205 Brooks Ave N. TRF, MN 56701

HRN: _____

PATIENT APPLICATION FOR CARE

(LEAVE NOTHING BLANK WRITE N/A IF IT DOES NOT PERTAIN TO YOU)

PATIENT DEMOGRAPHICS

Name: _____ **Birth Date:** _____-_____-_____ **Age:** _____ ☐ **Male** ☐ **Female**

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

E-mail Address: _____ **Home Phone:** _____

Mobile Phone: _____ **Work Phone:** _____

Employer: _____ **Occupation:** _____

Name of Emergency Contact: _____**Phone Number:** _____**Relationship:** _____

Height: _____ **Weight:** _____ **Who May we Thank for Referring you?**_____

HISTORY of COMPLAINT(S)

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 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 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 evening ❑ Pain radiates to_____
4. _____ **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_____

On a scale of **1 to 10** with**10** being the **worst** pain and **0** being **no** pain, rate how you feel today ***(Circle the number)*:**

First (chief) complaint:	0	1	2	3	4	5	6	7	8	9	10
Second complaint:	0	1	2	3	4	5	6	7	8	9	10
Third complaint: :	0	1	2	3	4	5	6	7	8	9	10
Fourth complaint: :	0	1	2	3	4	5	6	7	8	9	10

PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms: **R = R**adiating **B = B**urning **D = D**ull **A = A**ching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

Do your symptoms cause you to feel **worse**: ☐ AM ☐ PM ☐ mid-day ☐ late PM

Have these problems ever been treated by anyone in the past? ☐No ☐Yes

If yes by who: _____**How long ago?** _____

What **type** of treatment did you receive? _____

What were the **results?** ☐ Favorable ☐ Unfavorable → **If unfavorable** please explain:

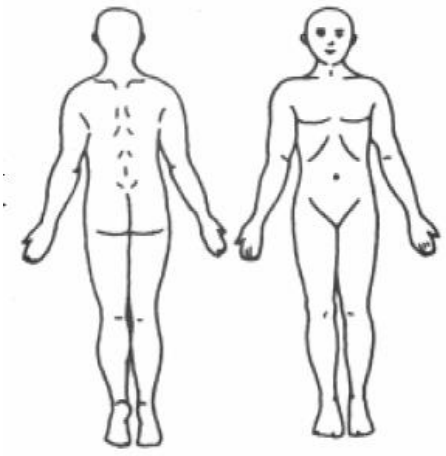
_____

List any **medications** taken to treat these conditions: _____

Did they help? ☐ No ☐ Yes If you still take them, how often? _____

Have you ever been under chiropractic care? ☐ No ☐ Yes **If yes,** how long ago: _____

Name of previous chiropractor: _____



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Accidents/Work Injuries/ Car accidents

Are any of your problem(s) today the result of ANY TYPE of **recent accident**? ☐ No ☐ Yes
If yes, How long ago? _____ Please explain what type of accident:
_____

PAST HISTORY

1. If you have ever been diagnosed with any of the following conditions please indicate with a **P** for in the **Past, C** for **Currently** have and **N** for **Never** have had:

___ Heart Attack ___ Dislocations ___ Tumors ___ Stroke ___ Rare Blood disease ___ Seizures
___ Broken Bone ___ Concussion ___ Disability ___ Cancer ___ Rheumatoid Arthritis ___ TMJ
___ Osteo Arthritis ___ Fracture ___ Diabetes ___ **Other serious conditions** :_____

2. PLEASE**,** identify **ALL PAST and** or any **unrelated current conditions** you feel may be contributing your **present problem:**

	HOW LONG-AGO	TYPE OF CARE RECEIVED	BY WHOM
PREVIOUS ACCIDENTS:			
ADULT DISEASES:			
SURGERIES:			
CHILDHOOD DISEASES:			

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational **Drug** use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. How many **years** of **school** did you complete? ❑ 1-8 ☐ 8-12 ☐ 12-14 ☐ 14-16 ☐ 16 +

Activities of Daily living (ADL):

What activities does your pain or discomfort limit you from doing either partially or totally?:

_____
_____
Any additional information you would like the Doctor to know:_____
_____

For Females Only:

PREGNANCY VERIFICATION

I have been given a full explanation of when I am mostly likely to become pregnant, and to the best of my knowledge, I **am/am not (circle one)** pregnant. I am consenting to have the diagnostic x-ray examination performed, which the doctor has determined is clinically indicated and necessary. The first day of my last menstrual cycle was on _____ (date).

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of radiation exposure to an unborn child, and I have conveyed my understanding of all risks associated with being x-rayed. INITIAL_____
****

Patient Signature: _____ **Date Completed:_____**

Doctors Signature. _____ Date Reviewed:_____

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Total Score _____

Name _____
PRINTED

_____
Signature

_____
Date

TRUE NORTH
True North Chiropractic Center, LLC
205 Brooks Ave N. TRF, MN 56701

HIPAA Privacy Act/Notice of Privacy Practice

This office is required to notify you writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information and how you may obtain access to that information. In addition, we are providing you with a list of potential circumstances under which by law, or in accordance with our office policy, we may disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Once you have read this 'Notice' please sign the last page and return only the signature page (page 3) to our front desk receptionist.

PERMITTED DISCLOSURES

For treatment purposes- discussion with other health care providers involved in your care.
Inadvertent disclosures- services may be rendered in an open treating area, which means open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
For payment purposes - to obtain payment from any insurance company or other available collateral source, OR to obtain a recent address on you in the event you move and do not leave a forwarding address, we may use your 'emergency contact information' in whatever way necessary to locate you and collect any outstanding sums you may owe the practice/doctor.
For workers compensation purposes- to process a claim or aid in investigation.
Emergency- in the event of a medical emergency we may notify a family member.
For Public health and safety - in order to prevent to or lessen a serious or eminent threat to the health or safety of a person or general public.
To Government agencies or Law enforcement, to identify or locate a suspect, fugitive, material witness or missing person.
For military, national security, prisoner and government benefits purposes.
Deceased persons –discussion with coroners, medical examiners and family members or others who were involved in the care or payment. for care of the decedent prior to death, Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
Change of ownership- in the event this practice is sold the new owners would have access to your PHI.
To send communications while you are being treated and we are receiving financial remuneration.
Speaking with the patient's guardian or representative regarding bill payment.
Providing therapy to patients in group settings.
We may discuss your PHI using personal mobile phones when necessary to facilitate discussion about your care and or record keeping of your care.
Any other uses of disclosures not described in the Notice of Privacy Practices will be made only after obtaining your prior written authorization.
Note: At any time, this office may update the list of ways your PHI may be used and all updates are deemed retroactive.

YOUR RIGHTS

To receive an accounting of disclosures.
To receive a paper copy of a more detailed /comprehensive Privacy Notice.
To request mailings to an address different than your residence.
You have the right to request and receive electronic copies of your records.
To request amendments to information, however like restrictions we are not required to agree to them.
You have the right to receive notification in the event of a breach of unsecured PHI.
To request restrictions on certain uses and disclosures and, however we are not required to comply with your request.
With advance notice of at least five business days to the practice you may inspect your records and receive one copy of your records at no charge.
You have the right to request and we as a covered entity will restrict disclosure of your personal health information to a health plan if disclosure pertains to a healthcare item or service which you have personally paid out of pocket for in full.
You have the right to NOT receive communications regarding fund raising and none will be sent to you unless you give us written authorization.

ADDITIONAL RESPONSIBILITIES OF THIS PRACTICE

We are required to obtain a separate signed authorization from you before your personal health information can be used in marketing and for any disclosures that constitute a sale of personal health information.
We are required to notify you and HHS in the event of a breach caused by any of our business associates.
We are responsible to look over our business associate contracts to ensure they comply with the Omnibus Rules and requirements.
With prior authorization from you, we may contact you to send you information concerning products or services and information related or unrelated to your health.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please call Angela Powell at 480-570-4204 If she is unavailable, you may make an appointment with our receptionist to see the Doctor within 2 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

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**********Patient Keeps this Page**********

REGARDING NOTICE OF YOUR RIGHT TO PRIVACY

Patient Name:_____ DOB: _____HR#:_____

My signature below is an acknowledgement that I have received a copy of True North Chiropractic Center Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information and have conveyed my understanding of this information to the doctor and do not have any question regarding my rights or any of the information I have received at this time.
I have been made aware that additional information regarding HIPAA and my rights is published in government newsletters, which are available to me online.

The first original page of this 'Notice' have been offered to me or given to me to keep.

_____ _____
Patient Signature **Date**

_____ _____
Witness (office) Date

_____ _____
Print Witness Name Date