PREMIER
sports and spine center

952.479.0043
8577 Columbine Road
Eden Prairie, MN 55344

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Address _____ Apt/Unit _____

City _____ State _____ Zip _____ Date of Birth _____

Employer/School _____ (Circle) Male Female

Home # (____)_____ Mobile # (____)_____ Email _____

Emergency Contact: Name(s) _____

Relationship _____ Contact # _____

Please let us know how you heard about our clinic!

____ Dr._____ ____ Personal Referral _____

____ Website _____ ____ Other _____

Appointment Reminders: How would you like to be reminded about future visits? (Please Circle one of each)

Text Email Phone Call One Day Before Two Days Before

Health Insurance Information

Company Name _____ Policy # _____

Group # _____ Policy Holder Name _____

Policy Holder Date of Birth _____ Relationship to Insured _____

Workers' Comp or Auto Accident Information (If applicable)

Plan Name _____ Claim # _____

Date of Accident/Injury _____ State of Incident _____ (Circle) Auto Work

Insurance Contact Information: _____

_____

Consent for Services and Informed Consent

A. **Consent for Treatment.** I hereby consent to the attending physician, referral physicians or their assistants, and designees of Premier Sports and Spine Center (PSSC) to examine, treat, and complete routine diagnostic radiologic procedures considered necessary or advisable.

B. **Release of Medical Records.** I agree that information from my medical record may be used by or given to physicians, providers, and/or staff as necessary for treatment, reviewing quality of care and PSSC's operations so long as any release of information is in compliance with the law.

C. **Informed Consent:** I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic tests on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

   I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

   I have read, or had it read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek.

D. **Personal Property.** I understand PSSC is not responsible for the loss of any valuables.

E. I have received/reviewed a copy of the PSSC's Notice of Privacy Practices.

By signing below, I consent to all of the above and I acknowledge that I understand the informed consent and have received/reviewed a copy of the PSSC's Notice of Privacy Practices.

Patient's Name (Print): _____ **DOB: _____**

Signature: _____ **Date: _____**

(If Patient's Representative, under what legal authority are you signing?)

Parent Guardian HealthCare Agent

Witness' Signature: _____ **Date: _____**

Premier Sports and Spine Center
8577 Columbine Road
Eden Prairie, MN 55344
Dr. Holly Westbrock DC, DACBSP, EMT, CSCS
Dr. Christopher Dean DC, EMT, ART
Dr. Nolan Mitchell DC, CCSP, CSCS
Dr. Michael Williams DC, CSCS, ART, FMT, GT

Patient Name _____

PATIENT CONDITION

Describe your major complaint(s): _____

_____

Date you first noticed symptoms: _____ Describe when they began: _____

_____

Have you had these symptoms before? ☐ YES ☐ NO If yes, when: _____

How often do you experience the symptoms?

- ☐ Constantly (76% - 100% of the day)
- ☐ Frequently (51% - 75% of the day)
- ☐ Occasionally (26% - 50% of the day)
- ☐ Intermittently (0% - 25% of the day)

How would you describe the symptoms?

☐ Sharp	☐ Shooting	☐ Stabbing	☐ Weakness
☐ Dull	☐ Burning	☐ Stiffness	☐ Throbbing
☐ Numb	☐ Tingling	☐ Cramps	☐ Achy

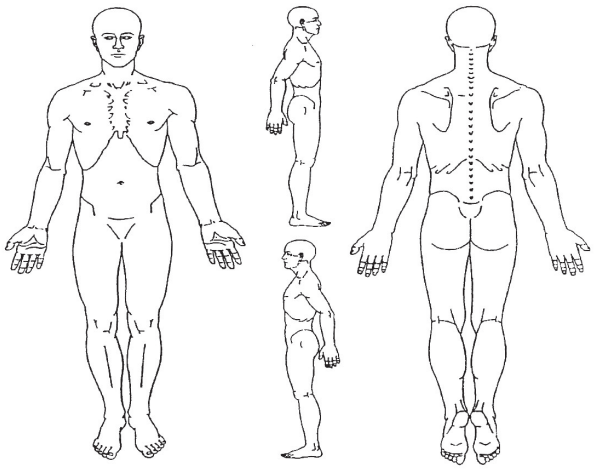
How are your symptoms changing?

☐ Getting Better ☐ Getting Worse ☐ No Change

How would you rate your symptoms at their:

	None									Unbearable
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

PLEASE MARK BELOW WHERE YOU HAVE SYMPTOMS



How do your symptoms affect your ability to perform daily activities?

0	1	2	3	4	5	6	7	8	9	10
No complaints	Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief			Severe, no activity possible

What makes your symptoms worse? _____

What makes your symptoms better? _____

Have you seen any other health care professionals for this condition? ☐ YES ☐ NO If yes, list the providers:

Name: Address: Date:

_____

_____

Have you had any tests done for your symptoms? ☐ YES ☐ NO If yes, please check test and give date.

☐ X-Rays _____ ☐ CT Scan _____ ☐ MRI _____ ☐ Lab _____ ☐ Other _____

Please indicate the findings if known: _____

Have you seen any other health care professionals for any other condition? ☐ YES ☐ NO If yes, please list:

Name: Address: Date:

_____

_____

Have you ever received chiropractic care before? ☐ YES ☐ NO If yes, please list:

Name: Address: Date:

_____

_____

HEALTH HISTORY

Place a mark on “Yes” or “No” to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Eating Disorder	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Rheum. Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Ringing in Ears	☐ Yes	☐ No
Ankle Swelling	☐ Yes	☐ No	Excessive Thirst	☐ Yes	☐ No	Loss of Balance	☐ Yes	☐ No	Shortness of		
Arthritis	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Loss of Sleep	☐ Yes	☐ No	Breath	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Fatigue	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bleeding			Fever	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Thyroid		
Disorder	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Multiple			Problem	☐ Yes	☐ No
Bowel/Bladder			General	☐ Yes	☐ No	Sclerosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Changes	☐ Yes	☐ No	Stiffness			Nausea	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Night Sweats	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Numbness	☐ Yes	☐ No	Unintentional		
Chemical			Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Weight Change	☐ Yes	☐ No
Dependency	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Vaginal		
Chest Pain	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Infections	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No	Heartburn	☐ Yes	☐ No	Pins/Needles			Venereal		
Cold Limbs	☐ Yes	☐ No	Heart Problem	☐ Yes	☐ No	Feeling in Limbs	☐ Yes	☐ No	Disease	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Visual Problem	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Herniated Disc	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate			Other _____		
Digestive			High			Problems	☐ Yes	☐ No	_____		
Problems	☐ Yes	☐ No	Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	_____		

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

- ☐ Smoking — Packs / Day _____
- ☐ Alcohol — Drinks / Week _____
- ☐ Caffeine — Cups / Day _____
- ☐ High Stress — Reason _____

Are you pregnant? ☐ YES ☐ NO Due Date: _____

INJURIES / SURGERIES / ACCIDENTS

	Description	Date
Falls:		
Head Injuries:		
Broken Bones:		
Dislocations:		
Surgeries (including Cosmetic):		
Automobile Accidents:		

MEDICATIONS

_____

_____

_____

ALLERGIES

_____

_____

_____

VITAMINS / HERBS / SUPPLEMENTS

_____

_____

_____