Rising Sun Chiropractic & Weight Loss
Dr. Seth Nelson & Associates

Patient Name:__________________________________ **Date:**____________________

Address_____________________________________

City_______________ State __________

Zip Code ___________

H. Phone __________________________

Cell Phone ________________________

Email Address: ______________________________

Sex M F Marital Status M S D W
Date of Birth_____________ Age___________
Spouse's Name _______________________________
Employer/School______________________________
Occupation__________________________________

Emergency Contact and Phone Number:
____

Who may we thank for referring you?
____

Have you ever received Chiropractic Care?
Yes No If yes, when? _____________________

Name of most recent Chiropractor:
____

Who is your Medical Provider?
____

1. **Past Health History:**
 A.Surgeries:
 Type of Surgery and
 Date:____
 ____

A. **Previous Injury or**
Trauma____

Have you ever broken any bones? Which? ______________________________

B. **Allergies:**
____

2. **Family Health History:**

Do you have a family history of? (Please circle all that apply to you and immediate family.)

Aids/HIV	Cancer	Headaches/Migraines	Ringing in Ears
Alcoholism	Cardiac Disease	Hepatitis	Scoliosis
Anxiety	Cholesterol	Immune Issues	Stroke
Aneurysm	Depression	Osteoporosis	TMJ Issues
Arthritis	Diabetes	Multiple Sclerosis	Urinary Issues
Asthma	Digestive Issues	Reproductive Issues	Auto Immune
Elbow/Wrist/Hand			

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Patient Name:________________________________ **Date:**____________________

3. **Social and Occupational History:**

   A. **Job description:** ____

   B. **Work schedule:** ____

   C. **Recreational activities/hobbies:**
   ____

   D. **Lifestyle:**

   Level of Exercise: Low Moderate Exceptional
   What type of exercise and how often?____
   Alcohol Use: ____
   Tobacco Use: ____
   Drug Use: ____

   E. **How would you grade your sleep? 1 2 3 4 5 6 7 8 9 10**
   What is your biggest challenge to getting good sleep?______________________________

   F. **How does stress impact your lifestyle?** ___________________________________
   ____

4. **Medications and Supplements:**

____

____

5. **What are your health goals?**

____

____

Other Relevant Medical Information:

____

____

NEW PATIENT HISTORY FORM   Primary Concern ____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ____
  - How did the symptom begin? ____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): ___________________________________

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): ___________________________

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff   Other (please describe): ____

- Does the symptom radiate to another part of your body (circle one):   yes   no
  - If yes, where does the symptom radiate? ____

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference   Morning   Afternoon   Evening   Night   Other ______________

Have you received treatment for this condition and episode prior to today's visit?

- No
- Anti-inflammatory meds
- Pain medication
- Muscle relaxers
- Trigger point injections
- Cortisone injections
- Surgery
- Massage
- Physical Therapy
- Chiropractic

NEW PATIENT HISTORY FORM   Symptom 2 ______________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ____
  - How did the symptom begin? ____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): _________________________________

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): __________________________

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff   Other (please describe): ____

- Does the symptom radiate to another part of your body (circle one):   yes   no
  - If yes, where does the symptom radiate? ____

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference   Morning   Afternoon   Evening   Night   Other _____________

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic

NEW PATIENT HISTORY FORM   Symptom 3 ____________________________________

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 1 2 3 4 5 6 7 8 9 10

- What percentage of the time you are awake do you experience the above symptom at the above intensity: 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

- Did the symptom begin suddenly or gradually? (circle one)
- When did the symptom begin? ____
  - How did the symptom begin? ____

- What makes the symptom worse? (circle all that apply):
  - nothing, any movement, bending neck forward, bending neck backward, tilting head to left, tilting head to right, turning head to left, turning head to right, bending forward at waist, bending backward at waist, tilting left at waist, tilting right at waist, twisting left at waist, twisting right at waist, driving, standing, walking, running, lifting, sitting, getting up from seated position, chewing, changing positions, lying down, reading, working, exercising, laying on side in bed, other (please describe): ______________________________

- What makes the symptom better? (circle all that apply):
  - nothing, resting, ice, heat, stretching, exercise, walking, pain medication, muscle relaxers, chiropractic adjustments, massage, other (please describe): _______________________

- Describe the quality of the symptom (circle all that apply):
  - Sharp, dull, achy, burning, throbbing, piercing, stabbing, deep, nagging, shooting, stinging, stiff   Other (please describe): ____

- Does the symptom radiate to another part of your body (circle one):   yes   no
  - If yes, where does the symptom radiate? ____________________________________

- Is the symptom worse at certain times of the day or night? (please circle)
  - No difference   Morning   Afternoon   Evening   Night   Other ____________

- Have you received treatment for this condition and episode prior to today's visit?
  - No
  - Anti-inflammatory meds
  - Pain medication
  - Muscle relaxers
  - Trigger point injections
  - Cortisone injections
  - Surgery
  - Massage
  - Physical Therapy
  - Chiropractic

Financial Policy

*In order to file your claims in a timely manner we need current, accurate insurance information for you and your dependents. We will do our best to confirm your eligibility and level of insurance coverage for chiropractic care. ***However, it is ultimately your responsibility to know your own insurance benefits in relation to what your insurance covers, and what it does not.***

*Should your insurance carrier determine that any or all of our services are ineligible for payment, you will be billed directly for those services.

*Payment for non-covered services, deductible and co-payment amount are due on the day of service (unless a monthly payment plan has been established for your treatment). If an invoice is mailed for a balance on account, the balance is due upon receipt.

*Accounts past 45 days old with **no attempt** at payment may be subject to an annual finance charge, which will be added monthly to that account.

*If you have any questions about your individual insurance, we encourage you to contact your insurance directly. We are happy to help answer any questions you may have, but ultimately your insurance carrier determines your coverage. If you have any questions about our financial policy, please ask to speak to our Office Manager. If you need to make special arrangements, please speak with Dr. Seth

.**We will not deny care to anyone based solely on ability to pay.**

Insurance Verification

Insurance Information

As a courtesy, we will bill your insurance company for you. Please note that this does not guarantee payment by your insurance and you are responsible for all charges that apply if your insurance fails to pay correctly and/or in a timely manner.

Patient Name:____

Patient Date of Birth:____________________

Subscriber's Name:____ Subscriber's Date of Birth:________________

I authorize the release of any medical information necessary to process this claim. I also authorize all claims to be sent directly to my insurance company and I authorize payment to be made directly to Rising Sun Chiropractic, PLC. I also agree to pay for any co-pay, deductible, or percentages designated as my responsibility. In the event that I should receive payment for these services, I agree to promptly remit payment to Rising Sun Chiropractic, PLC. I also accept personal responsibility for any balance due.

__________________________________ ____________________________

Patient or Responsible Party Signature **Date**

HIPAA NOTICE OF PRIVACY PRACTICES

Rising Sun Chiropractic & Weight Loss

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund-raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

____ ____________________

Signature of Patient or Representative **Date**

Informed Consent form Rising Sun Chiropractic + Weight Loss

St. Peter, MN 507-934-3333

PATIENT NAME:____

To the Patient: 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.

The nature of the chiropractic adjustment:

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my 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 have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment:

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

- **spinal manipulative therapy**
- **vital signs**
- **orthopedic testing**
- **muscle strength testing**
- **hot/cold therapy**
- **palpation**
- **range of motion testing**
- **basic neurological testing**
- **postural analysis testing**
- **laser therapy or EMS**

- **nutritional evaluations**
- **muscle therapies such as Graston and ART**

______ PLEASE INITIAL HERE TO SHOW YOUR CONSENT TO ALL THE ABOVE PROCEDURES. IF YOU OBJECT TO ANY PROCEDURES, PLEASE CIRCLE THOSE YOU OBJECT TO.

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, 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.

The probability of those risks occurring:

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and x-ray (where applicable). 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 the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal 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 arterial stroke.

The availability and nature of other treatment options:

Other treatment options for your condition my include:• Self-administered, over-the-counter analgesics and rest • Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers • Hospitalization • Surgery

If you choose to use one of the above noted "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.

The risks and dangers attendant to remaining untreated:

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.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Dr. Seth Nelson of Rising Sun Chiropractic, PLC to perform diagnostic tests and render chiropractic adjustments and other treatment modalities to my minor son/daughter: ____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the Doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Please answer the following:

· Do you have a pacemaker or bleeding disorder? Yes No · Are you currently taking blood thinners such as Coumadin? Yes No

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [X] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Seth Nelson and/or his qualified trained staff and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:__________________________ **Dated:**____________________

______________________________ ______________________________

Patient's Name **Witness**

______________________________ ______________________________

Signature **Signature**

______________________________ ______________________________

Signature of Parent or Guardian (if a minor)