

Last Name:		Middle:		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one)	
First Name:				<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Widow	
Email:				Birth date:		Age:	Sex:
Address:			City:		State:		
ZIP Code:		Home Phone:		Cell Phone:			
Social Security No:		How did you find us?					
Occupation:		Employer:			Work Phone:		
<b>Medical Care Information</b>							
Do You Have a Family Doctor?:		<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Doctor:					
Address:			City:		State:	ZIP Code:	
Date of last Visit: / /			Date of last exam: / /				
Do You Have a Family Chiropractor?:		<input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Chiropractor:					
Address:			City:		State:	ZIP Code:	
Date of last Visit: / /			Date of last exam: / /				
Have you had surgeries in the last 5 Years:		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Last Surgery Date:			
Reason for Surgery:							
<b>Is this a Vehicle Accident Injury? Y or N Date of Accident: _____</b>							
<b>Present illness /Conditions:</b>							
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Epilepsy		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Ulcer	<input type="checkbox"/>		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Polio	<input type="checkbox"/>		
<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> STD'S	<input type="checkbox"/>		
Other:							
<b>Family History of illness:</b>							
<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> STD'S			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Ulcer		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Mental/ Emotional Difficulty	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Polio		
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Scoliosis		
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diverticulitis		
Other:							
<b>Type of Cancer:</b>		<input type="checkbox"/> Breast <input type="checkbox"/> Lung		<input type="checkbox"/> Other:			
<b>Social History:</b>							
Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per week?		Cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes Packs per day?		Caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per day?		Exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes Hours per week? (circle one) Light / Moderate / Strenuous	

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

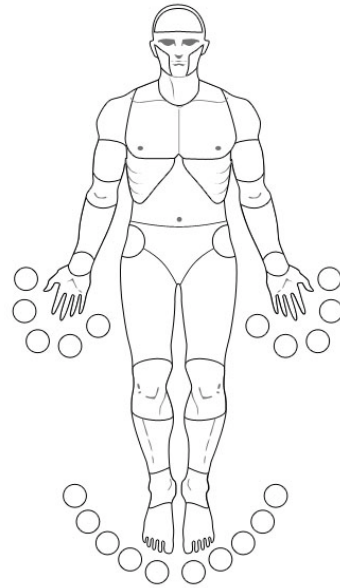
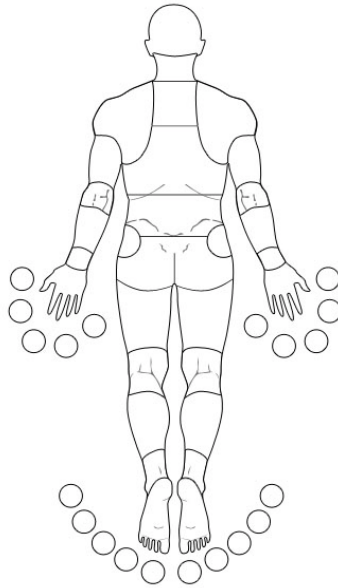
# CURRENT COMPLAINTS

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please indicate the current complaints you are experiencing by marking the areas on the image below and providing details using the sections that follow.

1. Headaches
2. Neck
3. Upper back
4. Mid Back
5. Lower Back
6. Hip
7. Buttock
8. Shoulder
9. Arm
10. Elbow
11. Forearm
12. Wrist
13. Hand
14. Fingers
15. Leg
16. Knee
17. Calf
18. Shin
19. Ankle
20. Foot
21. Toes
22. Chest
23. Ribs
24. Abdomen
25. Pelvis/Groin



<b>Area of Complaint</b>							
Describe Problem:							
Location	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Center						
Pain Ratings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 (Excruciating)						
Frequency	<input type="checkbox"/> Infrequent < 25% <input type="checkbox"/> Occasional 25% to 50% <input type="checkbox"/> Frequent 50% to 75% <input type="checkbox"/> Constant > 75%						
Pain Type	<input type="checkbox"/> No Pain <input type="checkbox"/> Pain <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Burning						
Severity	<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe						
What makes it better?	<input type="checkbox"/> Medication <input type="checkbox"/> Lying Down <input type="checkbox"/> Standing <input type="checkbox"/> Sitting <input type="checkbox"/> Stretching <input type="checkbox"/> Range of Motion <input type="checkbox"/> Nothing						
What makes it worse?	<input type="checkbox"/> Movements <input type="checkbox"/> Bending <input type="checkbox"/> Twisting <input type="checkbox"/> Weight Bearing <input type="checkbox"/> Movements <input type="checkbox"/> Neck flexion <input type="checkbox"/> Sneezing <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Chewing <input type="checkbox"/> Yawning <input type="checkbox"/> Opening mouth <input type="checkbox"/> Closing mouth <input type="checkbox"/> Range of motion <input type="checkbox"/> pushing/pulling <input type="checkbox"/> Lifting <input type="checkbox"/> Watching T.V. <input type="checkbox"/> Reading <input type="checkbox"/> Working <input type="checkbox"/> Driving <input type="checkbox"/> Housework <input type="checkbox"/> Bright lights <input type="checkbox"/> Loud Noises						
Does the pain radiate to any other locations?	<table border="0" style="width: 100%;"> <tr> <td style="background-color: #e0e0e0; width: 150px;">Upper Body</td> <td><input type="checkbox"/> Head <input type="checkbox"/> Forehead <input type="checkbox"/> Back of head <input type="checkbox"/> Right side of head <input type="checkbox"/> Left side of head  <input type="checkbox"/> Neck <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye  <input type="checkbox"/> Face <input type="checkbox"/> Right Jaw <input type="checkbox"/> Left Jaw  <input type="checkbox"/> Right Upper back <input type="checkbox"/> Left Upper back <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder  <input type="checkbox"/> Right Chest <input type="checkbox"/> Left Chest <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs</td> </tr> <tr> <td style="background-color: #e0e0e0;">Mid Body</td> <td><input type="checkbox"/> Right Mid back <input type="checkbox"/> Left Mid back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Left Lower back  <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Buttock <input type="checkbox"/> Left Buttock <input type="checkbox"/> Groin  <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right forearm <input type="checkbox"/> Left forearm  <input type="checkbox"/> Right hand <input type="checkbox"/> Left hand <input type="checkbox"/> Right fingers <input type="checkbox"/> Left fingers</td> </tr> <tr> <td style="background-color: #e0e0e0;">Lower Body</td> <td><input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee  <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes  <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes</td> </tr> </table>	Upper Body	<input type="checkbox"/> Head <input type="checkbox"/> Forehead <input type="checkbox"/> Back of head <input type="checkbox"/> Right side of head <input type="checkbox"/> Left side of head <input type="checkbox"/> Neck <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye <input type="checkbox"/> Face <input type="checkbox"/> Right Jaw <input type="checkbox"/> Left Jaw <input type="checkbox"/> Right Upper back <input type="checkbox"/> Left Upper back <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Chest <input type="checkbox"/> Left Chest <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs	Mid Body	<input type="checkbox"/> Right Mid back <input type="checkbox"/> Left Mid back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Left Lower back <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Buttock <input type="checkbox"/> Left Buttock <input type="checkbox"/> Groin <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right forearm <input type="checkbox"/> Left forearm <input type="checkbox"/> Right hand <input type="checkbox"/> Left hand <input type="checkbox"/> Right fingers <input type="checkbox"/> Left fingers	Lower Body	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes
Upper Body	<input type="checkbox"/> Head <input type="checkbox"/> Forehead <input type="checkbox"/> Back of head <input type="checkbox"/> Right side of head <input type="checkbox"/> Left side of head <input type="checkbox"/> Neck <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye <input type="checkbox"/> Face <input type="checkbox"/> Right Jaw <input type="checkbox"/> Left Jaw <input type="checkbox"/> Right Upper back <input type="checkbox"/> Left Upper back <input type="checkbox"/> Right Shoulder <input type="checkbox"/> Left Shoulder <input type="checkbox"/> Right Chest <input type="checkbox"/> Left Chest <input type="checkbox"/> Right Ribs <input type="checkbox"/> Left Ribs						
Mid Body	<input type="checkbox"/> Right Mid back <input type="checkbox"/> Left Mid back <input type="checkbox"/> Right Lower back <input type="checkbox"/> Left Lower back <input type="checkbox"/> Right Hip <input type="checkbox"/> Left Hip <input type="checkbox"/> Right Buttock <input type="checkbox"/> Left Buttock <input type="checkbox"/> Groin <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Arm <input type="checkbox"/> Right forearm <input type="checkbox"/> Left forearm <input type="checkbox"/> Right hand <input type="checkbox"/> Left hand <input type="checkbox"/> Right fingers <input type="checkbox"/> Left fingers						
Lower Body	<input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Knee <input type="checkbox"/> Left Knee <input type="checkbox"/> Right Calf <input type="checkbox"/> Left Calf <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot <input type="checkbox"/> Right Toes <input type="checkbox"/> Left Toes						
Described as	<input type="checkbox"/> Aching <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing						
At it's worst	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night After Activities: <input type="checkbox"/> Light <input type="checkbox"/> Moderate						
Associated with	<input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Visual Problems <input type="checkbox"/> Ringing/Buzzing ears <input type="checkbox"/> Bright light <input type="checkbox"/> Sensitivity <input type="checkbox"/> Loss of balance						
Comments							

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Healthletics Chiropractic Clinic, Consent to Services

## **PAYMENT, INSURANCE AND MEDICAL RECORDS**

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

I authorize payment of any medical benefits from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum now or hereafter owed this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

I understand and agree that health and accident policies are an arrangement between me and an insurance carrier. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

## **CONSENT TO TREATMENT OF A MINOR CHILD** *(Under the age of 18)*

I authorize Keith Okerstrom, DC and/ or his employees or his independent contractors to administer chiropractic and/or physical therapy services as deemed necessary to my child \_\_\_\_\_ (child's name).

\*\*\*Parent or guardian's name \_\_\_\_\_ and signature: \_\_\_\_\_

## **FEMALE PATIENTS ONLY**

This is to certify that, to the best of my knowledge, I am NOT pregnant and that Keith Okerstrom, DC has my permission to take x-rays. Beginning date of last menstrual period: \_\_\_\_\_

## **PATIENT'S RIGHTS**

Healthletics Chiropractic Clinic respects the unique difference of our patients, and will ensure that health care ethics are maintained for all patients. By signing this form I acknowledge that the HIPAA Patient Privacy Act document was made available and was found acceptable.

The following rights will be exercised on our patients' behalf:

- The patient has the right to considerate and respectful care.
- The patient has the right to and is encouraged to obtain from the doctor relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
- The patient has the right to know the identity of the doctor, staff, and all involved in patient care.
- The patient has the right to make decisions about the plan of care prior to and during the course of treatment, and to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
- The patient has the right to every consideration of privacy.
- The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases where reporting is permitted or required by law.
- The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the doctor of available and realistic patient care options.

**CONSENT TO USE NAME**

I authorize Keith Okerstrom, DC and/or Healthletics Chiropractic Clinic, LLC to use and/or disclose my name for the following: sign-in sheets and our annual patient appreciation letter.

**CONSENT TO CHIROPRACTIC AND/OR PHYSICAL THERAPY SERVICES**

I hereby request and consent to comprehensive examinations (*chiropractic, physical therapy, orthopedic, and/or neurological*), chiropractic adjustments/treatments (*and other procedures including various modes of physiotherapy modalities*), physical therapy intervention (*including soft tissue mobilization, therapeutic exercises, stretching, posture and ergonomic training, and home exercise programs*), nutritional counseling/advice, and diagnostic x-rays by Keith Okerstrom, DC and Healthletics Chiropractic Clinic, LLC, and employees or independent contractors of Healthletics Chiropractic Clinic, LLC, who now or in the future treat me in this office. I have had an opportunity to discuss with the doctor the nature and the purpose of the treatment indicated. I understand that results are not guaranteed and are informed that, as in the practice of medicine and the practice of chiropractic and physical therapy, there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest.

Healthletics Chiropractic Clinic reserves the right to cease treatment with any patient who proves to be non-compliant with medical advice including diagnosis or treatment recommendations.

I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic and/or employed staff.

**By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.**

**SIGNED**

**PRINTED**

**DATE**

\_\_\_\_\_

**\* IMPORTANT INFORMATION:**

**1)** This clinic will, as a courtesy, attempt to verify your health insurance benefits and eligibility. However, Healthletics Chiropractic cannot guarantee the accuracy of the information we collect from your insurance company. For this reason, it is ultimately your responsibility to be aware of your insurance plan, benefit limits, and annual maximums. Once services have been billed to the insurance company your bill is no longer eligible for our same-day, time-of-service discount. Please acknowledge that you will be financially responsible for fees that exceed your annual benefit maximum.

**2) Cancellation Policy for Massage Appointments: Same-day cancellations and missed appointments will be charged a \$25.00 fee.**

**Initial \_\_\_\_\_**



## Insurance Form

If you will be billing insurance, please fill out the form below. Healthletics will attempt to contact your insurance company to confirm your available benefits prior to your first appointment. If you have already given this information over the phone, then you ***do not*** need to fill out this form.

Patient Name	Date of Birth
Insured's Name	
Insurance Company	Phone
ID #	Group #