EVOLVE chiropractic

11820 Ulysses St. NE Ste. 140
Blaine, MN 55434
evolvechiromn@gmail.com
www.evolvechiromn.com

ADULT INTAKE FORM

PATIENT INFORMATION

First: _____MI _____ Last:_____ DOB _____/_____/_____ Sex: M / F

Address:_____City_____State:_____Zip:_____

Email: _____

Cell Phone: _____ ☐Yes! I want to opt in for text reminders

Occupation: _____ Employer:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Spouses Name:_____

Do you have children? ☐YES ☐NO If yes, please list names/ages:_____

How did you hear about us? ☐Screening/Event ☐Online Search ☐Social Media
☐Referral:_____

Please list the health concerns that prompted your first visit:

Health Concern (list according to severity)	Rate Severity 0= no pain – 10=unbearable	When did this problem begin?	Have you had this condition in the past?	Did problem begin with injury?	Are problems constant or intermittent?
1.			☐Yes ☐ No	☐Yes ☐ No	☐Constant ☐Intermittent
2.			☐Yes ☐ No	☐Yes ☐ No	☐Constant ☐Intermittent
3.			☐Yes ☐ No	☐Yes ☐ No	☐Constant ☐Intermittent

*PLEASE MARK **"C"** FOR **CURRENT** HEALTH CONCERNS or **"P"** FOR **PREVIOUS** HEALTH CONCERNS:

___ADD/ADHD
___Allergies
___Anxiety
___Arm Pain
___Asthma
___Back Pain - Low
___Back Pain - Mid
___Back Pain – Upper
___Bladder Disorders
___Chest Pain
___Chronic Fatigue
___Disc Problems
___Dizziness
___Ear Infections
___Epilepsy
___Fibromyalgia
___Food Sensitivities
___Gastric Reflux
___Headaches
___Heart Disorder
___Hip Pain
___Infertility
___Knee Pain
___Leg Pain
___Liver Disease
___Lupus
___Menstrual issues
___Migraines
___Neck Pain
___Nervousness
___Numbness in Arms/Hands
___Numbness in Legs/Feet
___Sciatica
___Sleep Issues
___Skin Issues
___Stomach Disorders
___Throat Issues
___Thyroid Problems
___TMJ
___Ulcers
___Vertigo
___Arthritis
___Sexual Dysfunction
___Prostate Problems

___Constipation ___Irritable Bowel ___Shoulder Pain ___Blood Pressure H/L

___Depression ___Kidney Problems ___Sinus Issues ___Other:_____

Have you seen other doctors for these concerns? ☐Yes ☐ No **If so, which type?** ☐Chiropractor ☐ Medical Doctor

☐Other _____

Location of pain (AREA OF MAIN CONCERN):_____

Please circle the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each.

Score the pain with **0 being no pain and **10 being worst possible pain.**

1. **How would you rate your pain RIGHT NOW?**

0 1 2 3 4 5 6 7 8 9 10

2. **What is your TYPICAL or AVERAGE pain?**

0 1 2 3 4 5 6 7 8 9 10

3. **What is your pain level AT ITS BEST (How close to "0" does your pain get at its best?)**

0 1 2 3 4 5 6 7 8 9 10

4. **What is your pain level AT ITS WORST? (How close to "10" does your pain get at its worst?**

0 1 2 3 4 5 6 7 8 9 10

The human body is designed to be healthy. The primary system in the body, which coordinates health and function, is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Many of the common health challenges that adults experience have their origins during the developmental years, starting at birth. Layers of damage to the spine and nervous system occur as a result of various traumas, toxins, and emotional stress. The result may be misalignment to the spinal column and damage to the nervous system – a condition called Vertebral Subluxation. Please answer the following questions to give us a better understanding about your state of wellness and factors which may be contributing to vertebral subluxation and *impeding your body's ability to heal.*

Have you ever been involved in an auto accident? ☐Yes ☐ No If yes, when? _____

Please describe any other traumas you have undergone: _____

_____

Please check any condition you have currently, or have had in the past:

☐ Stroke ☐ Cancer ☐ Heart Disease ☐ Spinal Surgery

☐ Seizures ☐ Spinal Bone Fracture ☐ Scoliosis ☐ Diabetes: Type_____

Please list all hospitalizations and surgical operations you have undergone within the corresponding year:

_____

Please list all medications you are currently taking:

How would a change in your health positively impact your life? *Please be specific with the goals you are hoping to achieve through your care at our office. (i.e. 'I could work out again, I could play with my grandchildren, etc')

Activities of Daily Living

Please identify how your current health concerns are affecting your ability to carry out activities that are routinely part of your life:

ACTIVITY:	**EFFECT:**			
Lifting/Carrying Objects	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Sit to stand	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Climbing Stairs	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Driving	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Extended Computer Use	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Exercise	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Household Chores	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Lifting Children	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Dressing	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Sexual Activity	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Sleep	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Sitting	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Standing	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Work/Job Tasks	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Walking	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Washing/Bathing	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Yard Work	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform
Concentration (Reading)	☐No Effect	☐Painful (can do)	☐Painful (limits)	☐Unable to Perform

Other:_____ ☐No Effect ☐Painful (can do) ☐Painful (limits) ☐Unable to Perform

Other:_____ ☐No Effect ☐Painful (can do) ☐Painful (limits) ☐Unable to Perform

EVOLVE CHIROPRACTIC NOTICE REGARDING YOUR RIGHT TO PRIVACY continued…

I have received a copy of Evolve Chiropractic's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name Date of Birth

_____ _____

_____ _____

Patient's Signature Today's Date

_____ _____

_____ _____

Witness Today's Date

_____ _____

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between *one instance per one million to one per two million*, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Evolve Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to any treatment method, and or techniques, within the doctor's scope of practice, which the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY ☐ *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ (Date)

□ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

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 ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date

EVOLVE CHIROPRACTIC NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to 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 and return only the signature page (page 5) to our front desk receptionist.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area mean 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.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
10. 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.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.

6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Alec Nassirzadeh D.C. at (612) 205-8154. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 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