EAGLE TRACE
SPINE & SPORT
NECK • BACK • INJURY

We are honored you chose use to evaluate your condition. Please fill out the information below so we may file your insurance forms. If you need assistance please ask the front desk person. Thank you.

NEW PATIENT INTAKE FORM

PERSONAL INFORMATION

Patient name _____ Date _____

Date of birth _____ Age _____ Sex M ☐ F ☐

Address _____ City _____ State _____ Zip _____

Mobile phone # _____ Home phone # _____ Work phone # _____

E-mail _____ Social security # _____

Employer name _____ Occupation _____

Spouse's name _____ Occupation _____

Emergency contact _____ Relationship _____ Phone _____

Child's name _____ Age ____ Sex M ☐ F ☐ Child's name _____ Age ____ Sex M ☐ F ☐

Child's name _____ Age ____ Sex M ☐ F ☐ Child's name _____ Age ____ Sex M ☐ F ☐

REFERRAL INFORMATION

How did you find out about us? _____

DESCRIBE THE COMPLAINT

What is your primary reason for this visit? _____

What caused the onset? _____

Does the pain radiate/travel? If so, where? _____ When did it start? _____

Please indicate your rate of pain: **0=No Pain** ☐ **1=Minimal** ☐ **2=Very mild** ☐ **3=Mild** ☐ **4=Mild to Moderate** ☐
5=Moderate ☐ **6=Moderate to Severe** ☐ **7=Mildly Severe** ☐ **8=Severe** ☐ **9=Very severe** ☐ **10=Excruciating** ☐

How would you describe the sensation of your complaint?
Sharp pain ☐ **Shooting** ☐ **Numbness** ☐ **Tingling** ☐ **Dull ache** ☐ **Burning** ☐ **Throbbing** ☐ **Other** _____

How much has the complaint interfered with your normal work? (both work outside the home and house work.)
Not at all ☐ **A little bit** ☐ **Moderately** ☐ **Quite a bit** ☐ **Extremely** ☐

What makes it feel worse? _____ What makes it feel better? _____

TIMING AND DURATION

Since the onset of your complaint, how has it been changing? **Getting better** ☐ **Not changing** ☐ **Getting worse** ☐

How often do you experience this issue? **Constantly (100%)** ☐ **Frequently (75%)** ☐ **Occasionally (50%)** ☐ **Intermittently (25%)** ☐

Does your complaint worsen? If so, when? **Morning** ☐ **Midday** ☐ **Night** ☐ **Sleep** ☐ **Work** ☐ **Other** _____

PREVIOUS TREATMENT

Who have you seen for this condition? **Medical doctor** ☐ **Physical therapist** ☐ **Chiropractor** ☐ **Other** _____

Have you had chiropractic care in the past? **Yes** ☐ **No** ☐ **If so, when?** _____

RISK FACTORS

Do you have? **A pace maker** ☐ **Any metal implants/devices** ☐ **Are you pregnant? Yes** ☐ **No** ☐ **Maybe** ☐

Information was obtained from: Patient ☐ Parent/Guardian ☐ Child ☐ Other _____

Patient/Guardian Signature _____ **Date** _____

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NEW PATIENT INTAKE FORM

PAST HISTORY

Please list any other past health issues or conditions:

- ☐ **Autoimmune conditions** _____
- ☐ **Bladder or bowel issues** _____
- ☐ **Cardiovascular issues** _____
- ☐ **Head, eyes, nose, throat issues** _____
- ☐ **Musculoskeletal issues** _____
- ☐ **Neurological issues** _____
- ☐ **Respiratory issues** _____
- ☐ **Skin issues** _____

MEDICATION HISTORY

Please list any medications you are currently taking? _____

_____

What other supplements or vitamins are currently taking? _____

_____

INJURY AND SURGICAL HISTORY

What, if any, major injuries have you had? When? _____

_____

SOCIAL HISTORY

Do you use alcohol, caffeine, illicit drugs or tobacco products? _____

Do you exercise? How often? _____

Do you sleep well? How many hours a night? _____

Describe your diet: _____

Describe your job: _____

FAMILY HEALTH HISTORY

Please list any conditions or health issues anyone in your family currently has, or has had in the past: _____

_____

_____

_____

ACTIVITIES

So we may have an idea of your daily routine, please list your daily activities and favorite hobbies. _____

_____

Does you current condition affect your performance in these activities or hobbies? Yes ☐ No ☐

If so, how? _____

OTHER SERVICES

Are there other services you are interested in?

Pain Care ☐ **Corrective Care** ☐ **Wellness Care** ☐ **Massage** ☐ **Nutrition** ☐ **Active Release Technique (ART)** ☐

Information was obtained from: Patient ☐ Parent/Guardian ☐ Child ☐ Other _____

Patient/Guardian Signature _____ **Date** _____

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So we may better understand your unique condition, please complete the following information with regard to your current complaint. Thank you.

PRIVACY AND INFORMED CONSENT

PRIVACY POLICY — HIPPA NOTICE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) and specifically its Privacy Rule, I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that my PHI can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare provider that may be involved in my treatment directly or indirectly.
- Obtain payment or reimbursement from health coverage programs or others.
- Conduct normal healthcare business operation including routine aspects of operating a health related practice or business.

The privacy officer for Eagle Trace Spine may be contacted by mail by writing to 12002 County Road 11, Burnsville, MN 55337

INFORMED CONSENT — CHIROPRACTIC

I hereby authorize physicians and staff at Eagle Trace Spine and Sport to treat my condition as deemed appropriate. The doctor will not be held responsible for any preexisting medically diagnosed conditions. I certify that the about information is correct to the best of my knowledge. I will not hold my doctor or any staff member at Eagle Trace Spine and Sport responsible for any errors or omissions that I may have made at completion of the form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risk prior to initiating care. While chiropractic treatment is remarkable safe, you need to be informed about potential risks related to your care to allow you be fully informed before consenting treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care system, we cannot promise a cure for any symptoms, conditions or disease as a result of treatment in this office. An attempt to provide you with the very best is our goal, and if the results are not acceptable, we will refer you to another provider won we feel can further assist you.

Specific risk possibilities associated with chiropractic care:

- **Soreness** – Chiropractic adjustments and physical therapy procedures are sometime accompanied by post treatment soreness. This is normal and acceptable response to chiropractic care and physical therapy. While not generally dangerous, please advise your doctor if you experience soreness or discomfort.
- **Soft Tissue Injury** – Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor join ligament, tendon, or other soft issue injury.
- **Rib Injury** – Manual adjustment to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for preventative measures. Treatment is performed carefully to minimize such risk.
- **Physical Therapy Burns** – Heat generated by physically therapy modalities may cause minor burns to the skin. This rare, but it occurs, you should report it to your doctor or staff member.
- **Stroke** – Stroke is the most serious complication of chiropractic treatment. Most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.
- **Other Problems** – There are occasionally other type of side effects associated with chiropractic, while these are rare, they should be reported to your doctor promptly. Please understand Eagle Trace Spine and Sport has a open room adjustment area, we do provide a private room for treatments – please inform your doctor if you prefer a private room.

If you have any questions concerning this form or above statements, please ask your doctor. Having carefully read above, I hereby give informed consent to have chiropractic treatment administration.

Patient Name (please print) _____

Patient/Guardian Signature _____ **Date**_____

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This is a summary of our clinic policies. We believe that a clear definitions allow us both to concentrate on the most important issue; regaining and maintaining your health. We are happy to answer any questions you have about your account.

OFFICE POLICY

PAYMENT POLICY FOR PATIENTS WITH INSURANCE

Eagle Trace Spine and Sport will file your insurance claim for you, and will attempt to verify coverage of services to be performed. We will review this information with you and explain what services (if any) are not covered that you will be responsible for. You are responsible for the balance on your account for any professional services rendered if you insurance denies coverage. Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed at 10% interest charge. Payment plans are available,but you must contact our office to setup these plans. Additional notes about insurance coverage:

- Copays are due at the time of service
- You may be responsible for a Deductible Amount. This amount is deemed 'Patient Responsibility.' Our office will bill you for this amount following our offices receipt of an 'Explanation of Benefits' (EOB) from your insurance company.
- You may be responsible for the co-insurance amount (% responsibility). Our office will bill you for this amount following our offices receipt of an Explanation of Benefits (EOB) from your insurance company.
- You may choose to make payment in advance of receiving a bill from any amount considered patient responsibility.

PAYMENT POLICY FOR PATIENTS WITHOUT INSURANCE

You have the option of paying in full on the date of service, paying in advance for your services or receiving a bill from our office. Discounts apply for payment in advance and payment made on the same day. You are responsible for the balance on your account for any services rendered. Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed a 10% interest charge.

APPOINTMENT POLICIES — CHIROPRACTIC

In order for us to better serve all patients, please call if you will be late or unable to keep your scheduled appointment.

APPOINTMENT POLICIES — MASSAGE

- **Cancellation Policy**: If you cannot make your appointment we ask you please contact our office 24 in advance to cancel. If your appointment is not canceled 24 hours in advance it will be considered a 'No Show' and subject to our 'No Show' policy.
- **No Show Policy:** If you fail to cancel your appointment according to the cancellation policy you are considered a 'No Show' and will be unable to schedule you next appointment without providing payment in advance. If you fail to redeem this appointment time of fail to cancel according to the 'Cancellation Policy' you will surrender your payment for this appointment. The 'No Show' fee is $40 for every occurrence.
- **Refusal of Service Policy**: We reserve the right to refuse to provide services to any person at anytime. Should you be denied service, you will be reimbursed for any unused services that have been paid in advance.

By signing, I acknowledge having received and read the above 'Office Policy.' I hereby agree to the terms and conditions outlined.

Patient Name (please print) _____

Patient/Guardian Signature _____ **Date**_____