RIVERTOWN CHIROPRACTIC & WELLNESS
5640 Memorial Ave N, Stillwater, MN 55082
(651) 439-2712

ABOUT THE PATIENT

Name ________________________________ Today's Date_____________ Birthdate ____________ Age______

Address ______________________________________ City ____________________ State ______ Zip _________

Home Phone _______________ Cell Phone _______________ Work Phone ____________ Gender ❑ M ❑ F

Marital Status: M D S WPartner's Name ____________________ Kid's Names and Ages____________________

Your Employer ___________________________ Type of Work ________________________________

e-Mail Address ___________________________________ Have you been to a chiropractor before? ☐ No ☐ Yes

Emergency Contact _________________________________ Ph # _____________________________

How Did You Hear About Us?__________________ Whom May We Thank For Referring You?________________

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? ____________________
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance, my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

____ ____________________

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

MAIN COMPLAINTS (check all that apply) ❑ KNEE ❑ NEUROPATHY ❑ NECK ❑ BACK ❑ OTHER ________________

How long has it been an issue? ___________________________ Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing

❑ Constant ❑ Swelling ❑ Hot Sensation ❑ Pins & Needles ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening

Does the pain radiate? ❑ Yes ❑ No If so, where? _________________________

What is the worst pain you've experienced with this issue? (1 None – 10 Extreme) 1 2 3 4 5 6 7 8 9 10

Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Sitting to Standing Position ❑ Driving ❑ Walking

How did your symptoms begin? ____

What makes it worse? ______________________ Better?______________________

What Doctors have you seen for this?____

Types of treatment:______________________________ Did it help?______________

Anything else bothering you? ____

Previous auto accidents or work-related injuries? ❑ Yes ❑ No If yes, please describe

____

Other types of injury (sports, recreational): ____________________________________

List any past hospitalizations and surgeries: ____________________________________

____

Mark all areas of concern

COVID-19 - In the past 14 days have you or anyone close to you have symptoms of a

❑ Fever ❑ A new cough ❑ Shortness of breath ❑ New loss of taste or smell

RIVERTOWN CHIROPRACTIC & WELLNESS
5640 Memorial Ave N, Stillwater, MN 55082
(651) 439-2712

GENERAL HEALTH HISTORY

Patient Name____________________________________ *Mark the conditions that apply to you.*

Past	Present	Condition
❑	❑	Headaches/Migraines
❑	❑	Asthma/Allergies
❑	❑	Neck Pain
❑	❑	Lower Back Pain
❑	❑	Sciatica
❑	❑	Herniated Disc/Bulging Disc
❑	❑	Spinal Arthritis/Degeneration
❑	❑	Spinal Stenosis
❑	❑	Shoulder Pain
❑	❑	Knee Pain
❑	❑	Plantar Fasciitis
❑	❑	Joint Replacement
❑	❑	Extremity Numbness
❑	❑	Pinched Nerve
❑	❑	Metal Plates/Surgical Screws

Past	Present	Condition
❑	❑	Diabetes
❑	❑	Vascular Problems
❑	❑	Cancer/Chemotherapy
❑	❑	Neuropathy
❑	❑	Heart Attack/Stroke
❑	❑	Pacemaker
❑	❑	High/Low Blood Pressure
❑	❑	High Cholesterol
❑	❑	Digestive Problems
❑	❑	Metabolic/Weight Problems
❑	❑	Poor Circulation/Wound Healing
❑	❑	Balance or Difficulty Walking
❑	❑	Regular Exercise
❑	❑	Other ____________________

List any medications/supplements you are taking:____

____

Exercise
- ❑ None
- ❑ Moderate
- ❑ Daily

Work Activity
- ❑ Sitting
- ❑ Standing
- ❑ Light Labor
- ❑ Hard Labor

Habits
- ❑ Smoking
- ❑ Alcohol
- ❑ Coffee/Caffeine Drinks

FAMILY HISTORY

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other__________________

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other__________________

Is there any other family history you want us to know?____

QUALITY OF LIFE

What are you afraid this might be (or beginning) to affect (or will affect)? ❑ Job ❑ Kids ❑ Marriage ❑ Future Ability ❑ Self-Esteem ❑ Sleep ❑ Time ❑ Finances ❑ Freedom How? ________________________________

Are there health conditions you are afraid this might turn into? ❑ Family Health Problems ❑ Heart Disease ❑ Arthritis ❑ Surgery ❑ Depression ❑ Diabetes ❑ Cancer ❑ Other ________________________________

What are you most concerned with regarding your problem? ________________________________

If you had to accept some level of pain, what would an acceptable level be? 1 2 3 4 5 6 7 8 9 10

I hereby certify that the information provided is true and accurate.

Patient Signature__________________________ **Date**_______________ **Doctor Signature**__________________________