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

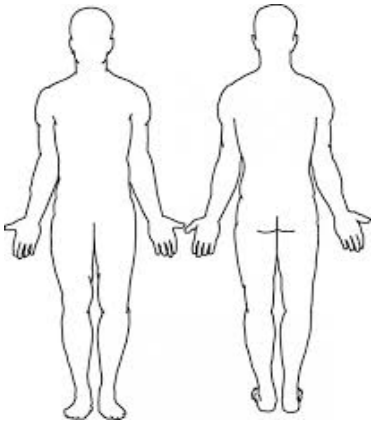
_____

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

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GENERAL HEALTH HISTORY

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

Past	Present		Past	Present	
❑	❑	Headaches/Migraines	❑	❑	Diabetes
❑	❑	Asthma/Allergies	❑	❑	Vascular Problems
❑	❑	Neck Pain	❑	❑	Cancer/Chemotherapy
❑	❑	Lower Back Pain	❑	❑	Neuropathy
❑	❑	Sciatica	❑	❑	Heart Attack/Stroke
❑	❑	Herniated Disc/Bulging Disc	❑	❑	Pacemaker
❑	❑	Spinal Arthritis/Degeneration	❑	❑	High/Low Blood Pressure
❑	❑	Spinal Stenosis	❑	❑	High Cholesterol
❑	❑	Shoulder Pain	❑	❑	Digestive Problems
❑	❑	Knee Pain	❑	❑	Metabolic/Weight Problems
❑	❑	Plantar Fasciitis	❑	❑	Poor Circulation/Wound Healing
❑	❑	Joint Replacement	❑	❑	Balance or Difficulty Walking
❑	❑	Extremity Numbness	❑	❑	Regular Exercise
❑	❑	Pinched Nerve	❑	❑	Other _____
❑	❑	Metal Plates/Surgical Screws			

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**_____

PAYING FOR CARE IS EASY *Select which option works best for you!*

_____ Custom Care Plan/No Insurance: Our care plans and simple payment arrangements have helped thousands of people and are sure to work great for you too! These days, insurance pays very little for natural, drugless care which is why many patients decide not to utilize their insurance coverage. The care provided will not be submitted to insurance, however, the cost for care is affordable and can be broken down into monthly budget-friendly payment options that are discussed prior to starting. We will **never** surprise you with a bill in the mail! Don't worry, you can still use your HSA or FSA dollars here!

_____ Custom Care Plan/With Insurance: These days, insurance pays very little for natural, drugless care. Insurance companies put a limitation as to how many visits/adjustments we are able to bill on your behalf (typically between 6 and 10 visits). We will follow each insurance companies' guidelines and ensure your care is eligible for coverage. Because we have a provider contract with each insurance company, we will do our best to estimate your out of pocket expenses, so you'll know what to expect for your care!

_____ Auto Injury: Auto-related injuries are covered at 100% in MN - even if you were at-fault or were a passenger! You can get the care you need; we'll take care of the rest! Your insurance MAY even cover PEMF, EPAT, Neck on Trac, Back on Trac, and even our Knee on Trac!

_____ Work Injury: Work injuries are covered at 100% for up to 12 weeks of treatment. You can get the care you need; we'll take care of the rest! Your insurance MAY even cover PEMF, EPAT, Neck on Trac, Back on Trac, and even our Knee on Trac!

_____ Medicare: Regardless of your condition, Medicare pays for **active care** adjustments only. They have very strict rules and limitations. Medicare examinations are required to show you are eligible for care, but Medicare does NOT cover them ($50). Maintenance care is not a covered service through Medicare, but we offer a discounted rate of $42/visit.

For Your Convenience*:*

We like to make things as easy as possible for our patients - including paying for care! Prior to beginning treatment, we will go over all costs anticipated with your customized plan. Feel comfortable knowing we use a secure portal to hold your credit card information and only process payments if:

- *You give us **authorization.***
- *You have been **billed for at least 2 months** and **payment** on your account was **not received**. At that time, we will run the card on file for the outstanding balance.*
- *If you chose to **discontinue care before your plan has been completed**, an account reconciliation will be performed, and a payment or credit will be issued.*

Sign Name _____ **Date: _____**