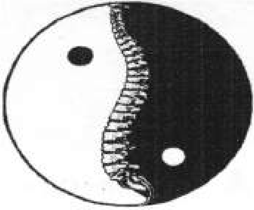


Moua-Lor Chiropractic & Acupuncture, P.A.
5600 Bass Lake Rd, Suite D, Crystal, MN 55429
Phone: (612) 529-0202 Fax: (612) 521-1445

PLEASE PRINT: DATE: ______/______/______

NAME (First, middle, last): ______________________ Email: ______________________

STREET ADDRESS: ______________________

CITY/STATE/ZIP: ______________________

SEX: ☐ FEMALE ☐ MALE

CELL PHONE: (______) ______________________

BIRTHDATE: ______/______/______ HOME PHONE: (______) ______________________

WORK PHONE: (______) ______________________

SOCIAL SECURITY NO: ________-________-________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED

EMPLOYMENT STATUS: ☐ EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ HOMEMAKER ☐ FULL-TIME STUDENT ☐ PART-TIME STUDENT

EMERGENCY CONTACT INFORMATION:

______________________ (First, Middle, Last Name) ______________________ (Phone Number) ______________________ (Relationship to Patient)

EMPLOYMENT INFORMATION:

______________________ (Work Title) ______________________ (Company Name)

______________________ (Company Address) ______________________ (City, State, Zip Code)

HISTORY OF PRESENT ILLNESS/INJURY: ☐ Other ______________ ☐ Work Injury Date: ____/____/____

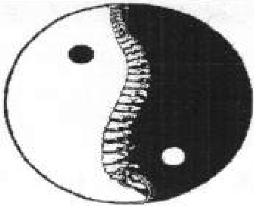
☐ Car Collision Date: ____/____/____

______________________ (Name of Insured in Car Policy) ______________________ (Date of Birth) ______________________ (Relationship to Patient)

______________________ (Car or WC Insurance Company Name) ______________________ (Car or WC Claim Number)

Medical card(s) (make copy): ______________________
(Name of medical insurance card(s))

Do you have **Medicare**? (card with blue and red line) (make copy): ☐ No ☐ Yes



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Patient name: ______________________ DOB: ______________ Date of Injury: ______________

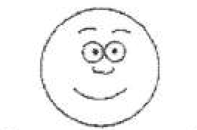
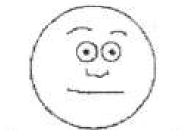
CHIEF COMPLAINTS:
Check where you are hurting:

- ☐ Headaches
- ☐ Dizziness
- ☐ Neck
- ☐ Upper Back
- ☐ Mid-Back
- ☐ Lower Back
- ☐ L/R Shoulder
- ☐ L/R Ankle
- ☐ L/R Arm
- ☐ L/R Leg
- ☐ L/R Knee
- ☐ Chest wall
- ☐ Others: ______________

Accident Description? (Circle)

Rear-ended Front impact Side Impact

Pain scale: (circle your pain)

No Pain | Mild Pain | Moderate Pain | Severe Pain | Very Severe Pain | Worst Possible Pain

Please describe your pain:

Circle your frequency of pain: constant, comes and goes, getting better/worse, or staying the same

Circle your pain feeling: dull aching, sharp, stiff, stabbing, burning, tight, inflamed, numbness or tingling.

What makes the condition better?

- ☐ Take prescribed medications
- ☐ Massage
- ☐ Take OTC (over-the-counter) medications
- ☐ Other: ______________

What makes the condition worse?

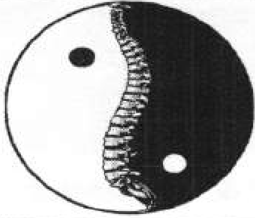
- ☐ Standing ☐ Bending
- ☐ Sitting ☐ Lifting
- ☐ Lying ☐ Twisting
- ☐ Other ______________

Any loss of bladder/bowel control? Yes or No

Any activities that make your pain worse? ______________

PAST MEDICAL HISTORY:

1. Have you ever seen a chiropractor before? ☐ No ☐ Yes If yes, when? ______________
   Doctor's name and location? ______________
2. Have you been in a car accident in the past? ☐ No ☐ Yes If yes, when? ______________
   Was anything injured? ☐ No ☐ Yes If yes, what? ______________



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Patient name: ______________________ DOB: ______________ DOI: ______________

PAST MEDICAL HISTORY (cont.):

3. A.) Do you have a family doctor? ☐ No ☐ Yes
   B.) Doctor's name/clinic and address? ______________________
   C.) Have you seen a medical doctor for this condition? ☐ No ☐ Yes If yes, when? ______________
   D.) Doctor's name/clinic and address? ______________________
   E.) Do you see your doctor for any other conditions? (Diabetes, high blood pressure, high cholesterol, other):
   F.) Do you take any prescribed medication for your current condition or other conditions? ☐ No ☐ Yes
   G.) Do you have Hepatitis B (mob kab siab B) or Tuberculosis (TB) (mob ntsws qhuav)? ______________
4. Have you been hospitalized or had surgery in the past? ☐ No ☐ Yes If yes, when? ______________
   Hospital name and address? ______________________
   Reason for hospitalization? ______________________
5. Allergies? ☐ No ☐ Yes If yes, explain______________________
6. Do you have any broken bones? ☐ No ☐ Yes If yes, where? ______________________

SOCIAL HEALTH HISTORY:

7. Are you a smoker? ☐ No ☐ Yes If so, how many per a day? ______________
8. Do you consume caffeine? ☐ No ☐ Yes If so, how much per day? ______________
9. Do you consume alcohol? ☐ No ☐ Yes If so, how many glasses per day? ______________
10. Do you exercise? ☐ No ☐ Yes If yes, what? ______________
11. **FOR FEMALE PATIENTS ONLY:**
    Are you pregnant or is there any possibility that you may be pregnant? ☐ No ☐ Yes
    If so, how many days, weeks, or months? ______________

FAMILY HEALTH HISTORY:

Health Status: (If deceased, from what?)
Father: ______________________
Mother: ______________________
Sisters: ______________________ How many? ________
Brothers: ______________________ How many? ________
Children: ______________________ How many? ________

______________________ ____/____/____
(Patient or other legally authorized person signature) (Date)

Moua-Lor Chiropractic & Acupuncture, P.A.

Important Authorizations Please initial each section and sign at the bottom of page.

Patient Name (please print) ______________________________

______ (Initial) **Financial Policy**

For your convenience, Moua-Lor Chiropractic & Acupuncture, P.A., when appropriate, will submit eligible and approved claims to your health insurance carrier or to the appropriate insurance carrier. However, the patient, guarantor, or customer regardless of insurance coverage, is ultimately responsible for the payment of services received. At each visit, you will be asked to verify your insurance coverage and to pay, if required, any co-pays or deductibles. Payment for any non-covered services received from Moua-Lor Chiropractic & Acupuncture, P.A. is due at the time of your visit.

______ (Initial) **Assignment of Benefits**

I hereby authorize direct payment to Moua-Lor Chiropractic & Acupuncture, P.A. of any medical benefits otherwise payable to me for services provided by Moua-Lor Chiropractic & Acupuncture, P.A.

______ (Initial) **Records Release**

I hereby authorize Moua-Lor Chiropractic & Acupuncture, P.A., to release my records to my insurance company and/or treating physician(s) for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are submitted for insurance claim processing or as long as dictated by payer.

______ (Initial) **Notice of Privacy Practices**

I'm notified that my information will be kept confidential as per the law.

______ (Initial) **Email, Text, or Electronic Communications**

My signature below indicates that I understand if I initiate communication to Moua-Lor Chiropractic & Acupuncture, P.A., via email, fax, voice, text, or other forms of electronic communication that I am agreeing to receive communication back from Moua-Lor Chiropractic & Acupuncture, P.A. via email, fax, voice, text, or other forms of electronic communication.

______ (Initial) **Consent to Treatment**

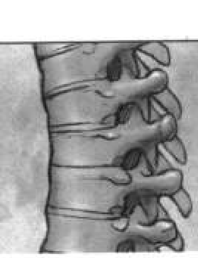
I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations, and treatment.

I certify that I have read this form and understand its content.

____

Signature of patient/client or personal representative   Date

Original



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CHIROPRACTIC CONSENT FORM

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my conditions. I also understand that this is a teaching clinic and that student observers may be present during treatment. Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serous risks associated with the chiropractic adjustment are extremely rare. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments. **Dizziness, nausea, flushing:** These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care. **Fractures**: When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under case, you will be informed, and your treatment pain will be modified to minimize risk of fracture. **Disc Herniation or prolapses:** Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. it is important to notify your chiropractic if symptoms change or worsen. **Stroke:** A certain extremely rare type of stroke has been associated with chiropractic care. Although these is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractor and medical visits is likely explained by patients with neck pain and headache consulting both Doctors of Chiropractic and primary care medical doctors before or during their stroke. **Other risks:** associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat. **Bruising:** Instrument assisted soft tissue manipulation may result in temporary soreness or bruising.

I understand that the practice of chiropractic, like the practices of all the healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

I have read this informed consent document. I have made my decision voluntarily and freely.

Patient's Name:(Print) ________________________________ Date of Birth ____________________

________________________________ ______________

Patient / Guardian Signature Date

ORIGINAL