# ABOUT THE PATIENT

AT Ease Health and Wellness
P: 763-331-0550 F: 763-331-0389
9405 36 Ave N, Suite E, New Hope, MN 55427

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Gender ❑ M ❑ F Veteran / 1st Responder ❑ Y ❑ N

Significant Other'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 # _____

Name of Medical Doctor(s)_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize At Ease Health & Wellness to release and / or request records to or from other providers as may be necessary.
- 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

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

6. What makes it better? _____

7. What makes it worse? _____

8. What doctors have you seen for this? _____

_____

9. Type of treatment: _____

10. Results: _____

NOTES: _____

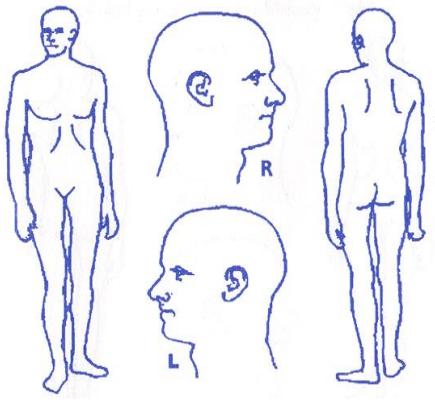
_____

_____

_____

FEMALES:
Are you pregnant?
❑ Yes ❑ No

Please mark all areas of concern.



# GENERAL HEALTH HISTORY

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

| Past | Present | | Past | Present | |
|---|---|---|---|---|---|
| ❑ | ❑ | AIDS/HIV | ❑ | ❑ | Headaches |
| ❑ | ❑ | Alcohol use | ❑ | ❑ | Heart problems |
| ❑ | ❑ | Allergies (Type: _____ ) | ❑ | ❑ | Herniated disc |
| ❑ | ❑ | Asthma | ❑ | ❑ | Kidney problems |
| ❑ | ❑ | Arthritis | ❑ | ❑ | Liver problems |
| ❑ | ❑ | Bleeding disorder (blood thinner use) | ❑ | ❑ | Medication side effects |
| ❑ | ❑ | Blood Pressure: Hi ____ ; Low ____ | ❑ | ❑ | Migraines |
| ❑ | ❑ | Bruise easily | ❑ | ❑ | Muscle aches |
| ❑ | ❑ | Breathing problems (COPD, shortness of breath, etc.) | ❑ | ❑ | Muscular disease |
| ❑ | ❑ | Cancer (Type: _____ ) | ❑ | ❑ | Numbness in leg / foot |
| ❑ | ❑ | Chest pains | ❑ | ❑ | Osteoporosis |
| ❑ | ❑ | Cholesterol high | ❑ | ❑ | Pain all over |
| ❑ | ❑ | Cold Hands or feet | ❑ | ❑ | Ringing in the ears |
| ❑ | ❑ | Dental problems | ❑ | ❑ | Scoliosis |
| ❑ | ❑ | Depression | ❑ | ❑ | Sleeping problems |
| ❑ | ❑ | Diabetes | ❑ | ❑ | Stroke History |
| ❑ | ❑ | Digestive problems | ❑ | ❑ | Tension / Irritability |
| ❑ | ❑ | Ear Problems | ❑ | ❑ | Thyroid problems |
| ❑ | ❑ | Fainting | ❑ | ❑ | Tobacco Use |
| ❑ | ❑ | Fibromyalgia | ❑ | ❑ | Urinary problems |
| ❑ | ❑ | Gall Bladder problems | ❑ | ❑ | Vision problems |

❑ ❑ Other _____

1. List any medications you are taking:_____

_____

2. Please list all doctors you are currently seeing: _____

_____

3. Has any doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name_____

# PAST HISTORY

4. List any past auto collisions: _____ Was any care received? _____
5. List any past work injuries: _____ Was any care received? _____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

# 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? _____