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: _____

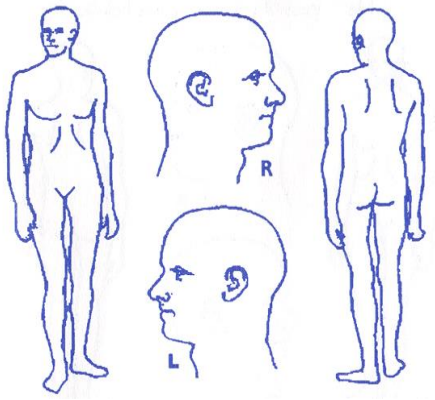
_____

_____

_____

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 your child.*

Past	Present		Past	Present	
❑	❑	ADHD	❑	❑	Headaches
❑	❑	Allergies (Type: _____)	❑	❑	Heart Problems
❑	❑	Asthma	❑	❑	Lung Problems
❑	❑	Bed Wetting	❑	❑	Medication Side Effects
❑	❑	Chronic Cold / Sinus	❑	❑	Recurring Fevers
❑	❑	Colic	❑	❑	Seizures
❑	❑	Dental Problems	❑	❑	Scoliosis
❑	❑	Digestive Problems	❑	❑	Stitches
❑	❑	Ear Infections (how many: _____)	❑	❑	Temper Tantrums
❑	❑	Growing Pains	❑	❑	Vision Problems
❑	❑	Other _____			

1. **List any medications being taken:** _____
2. **Number of courses of Antibiotics child has taken in the last 6 mos:** _____ **Total during lifetime:** _____
3. **Name of Pediatrician and Other Doctors:** _____
4. **Date of Last Visit** _____/_____/_____ **Reason:** _____
5. **Name of Obstetrician/Midwife:** _____
6. **Location of Birth:** ❑ **Hospital** ❑ **Birthing Center** ❑ **Home**
7. **Complications During Pregnancy:** ❑ **No** ❑ **Yes, Explain**: _____
8. **Ultrasounds During Pregnancy:** ❑ **No** ❑ **Yes, How Many**: _____
9. **Medication During Pregnancy / Delivery**: ❑ **No** ❑ **Yes,** List: _____
10. **Cigarette / Alcohol Use during Pregnancy:** ❑ **No** ❑ **Yes**
11. **Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor ":** ❑ No ❑ Yes, Name_____

PAST HISTORY

12. **List any past auto collisions:** _____ **Was any care received?** _____
13. **List any past falls bumps bruises:** _____ **Was any care received?** _____
14. **List any past sport, recreational, or home injuries:** _____
15. **Please describe any past conditions and treatment received:** _____

_____

16. **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? _____