# ABOUT THE PATIENT

Northern Roots Family Spinal Care 470 3rd Ave Clear Lake WI 54005

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Cell Carrier _____Gender ❑ M ❑ F

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)_____

Please check one of following: ❑ I am interested in crisis & emergency care only ❑ I am interested in care that will help get & keep me well

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Northern Roots Family Spinal Care 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 Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

NOTES: _____

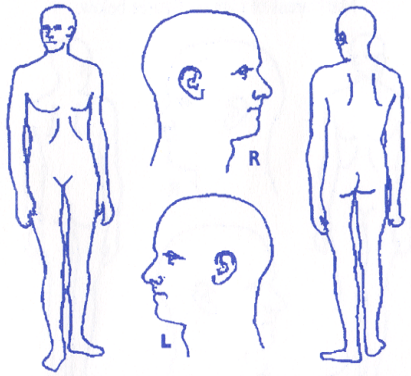
_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark all areas of concern.



# GENERAL HEALTH HISTORY

Northern Roots Family Spinal Care 470 3rd Ave Clear Lake WI 54005

Patient Name_____ DOB:_____ Mark the conditions that apply to you.

| Past | Present | | Past | Present | |
|---|---|---|---|---|---|
| ❑ | ❑ | Headaches | ❑ | ❑ | Urinary Problems |
| ❑ | ❑ | Migraines | ❑ | ❑ | Easy Bruising |
| ❑ | ❑ | Shortness of Breath | ❑ | ❑ | Tobacco Use (Cigarettes per day____?) |
| ❑ | ❑ | Allergies / Asthma | ❑ | ❑ | Dental Problems |
| ❑ | ❑ | Medication Side Effects | ❑ | ❑ | Fibromyalgia |
| ❑ | ❑ | Diabetes | ❑ | ❑ | Blood Thinner use |
| ❑ | ❑ | Hands or Feet cold | ❑ | ❑ | HIV Positive |
| ❑ | ❑ | Muscle aches | ❑ | ❑ | Cancer |
| ❑ | ❑ | Trouble Walking | ❑ | ❑ | Depression |
| ❑ | ❑ | Leg / Foot Numbness | ❑ | ❑ | Alcohol Use (drinks per day___?) |
| ❑ | ❑ | Fainting | ❑ | ❑ | ___High or ___Low Blood Pressure |
| ❑ | ❑ | Gall Bladder Trouble | ❑ | ❑ | Stroke History |
| ❑ | ❑ | Ringing in Ears | ❑ | ❑ | High Cholesterol |
| ❑ | ❑ | Ear Problems | ❑ | ❑ | TMJ |
| ❑ | ❑ | Sleeping Problems | ❑ | ❑ | Digestive Problems |
| ❑ | ❑ | Vision Problems | ❑ | ❑ | Pain all Over |
| ❑ | ❑ | Thyroid Problems | ❑ | ❑ | Tension / Irritability |
| ❑ | ❑ | Liver Disease | ❑ | ❑ | Chest Pains |
| ❑ | ❑ | Kidney Problems | ❑ | ❑ | Heart Pacemaker |
| ❑ | ❑ | Light Bothers Eyes | ❑ | ❑ | Heart Problems |
| ❑ | ❑ | Other _____ | | | |

1. List any medications you are taking:_____

_____

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

_____

3. Have you had the COVID-19 infection? ○ No ○ Yes If yes, how many times have you been infected? _____

4.Have you had the COVID-19 vaccination? ○ No ○ Yes If yes, how many booster shots? _____

# 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_____

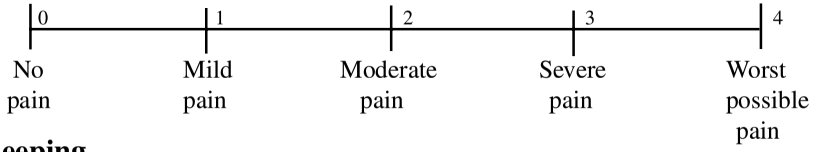
Is there any other family history you want us to know?_____

# Functional Rating Index

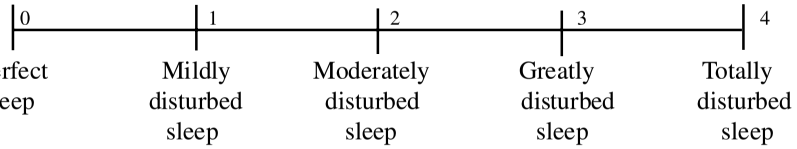
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

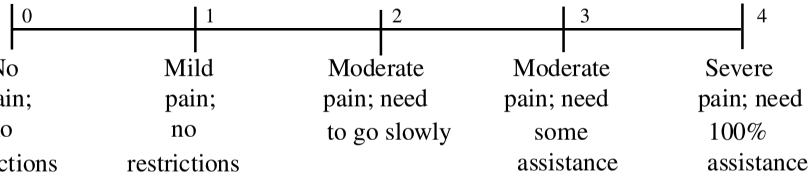
**1. Pain Intensity**



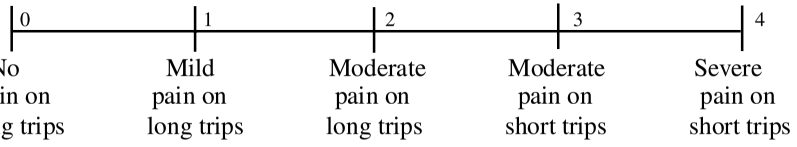

**2. Sleeping**



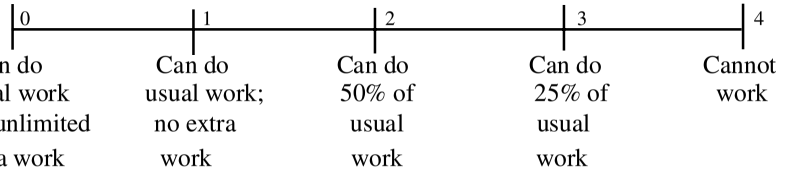

**3. Personal Care (washing, dressing, etc.)**



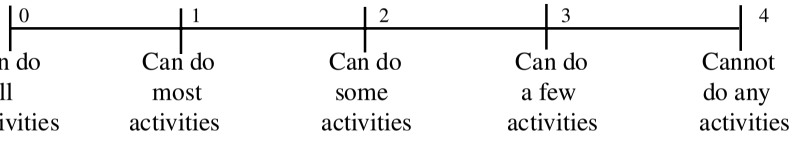

**4. Travel (driving, etc.)**



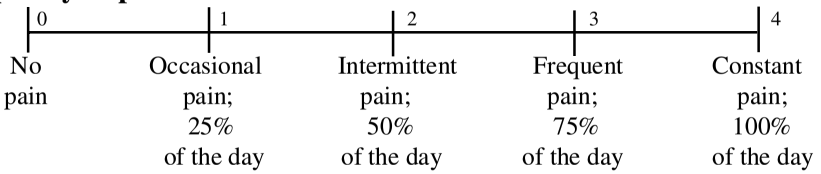

**5. Work**



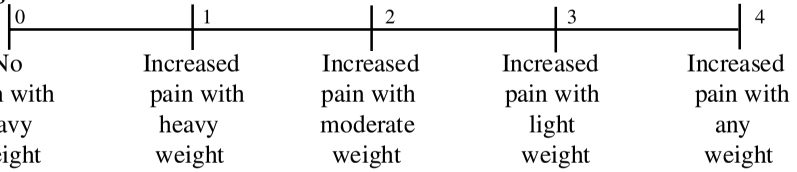

**6. Recreation**



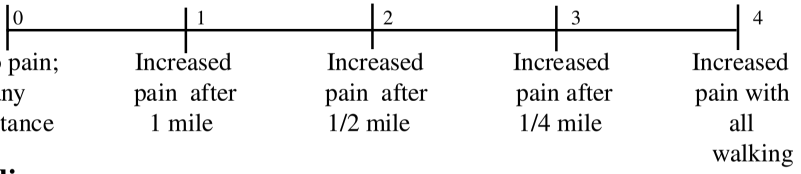

**7. Frequency of pain**



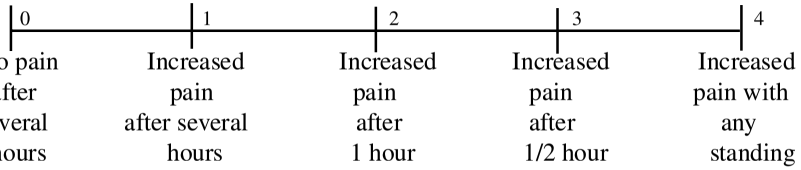

**8. Lifting**




**9. Walking**




**10. Standing**




**Name** _____
**PRINTED**

**Total Score** _____

_____
**Signature**

_____
**Date**

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# Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with the information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to; muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tracts was 1219 events per one million persons per year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to; self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____Signature: _____ Date: _____

Parent or Guardian: _____ Signature:_____Date: _____

Witness Name: _____ Signature: _____Date:_____

## Paying for your care is easy here!

Mark and initial which one is you:

**q No Insurance:** *Easy! Our Care Plans and simple payment arrangements have helped thousands of people and will work great for you too!

*Initial_____*

**q Health Insurance:** *These days, insurance pays very little if anything for natural drugless care to get you healthy. So we make it easy!
We will verify any benefits you may have and send your claims in to your insurance for you.
*If they pay anything after your deductible is met, we will accept payment directly from them.
*You are responsible for any deductible, co-insurance, co-pays and unpaid visits.
*Of course you can use your HSA, HRA and Flex dollars here!
*For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.

*Initial_____*

**q Auto Injury** *Auto related injuries are typically covered 100% in Wisconsin. Even if you were at fault or were a passenger. You can get the care you need. Great for you!
*All we need is your claim number, insurance, and attorney info.

*Initial_____*

**q Work Injury** *Work injuries are covered 100% for up to 12 weeks of care.
*All we need is your claim number and Work Comp ins. info.

*Initial_____*

**q Medicare** *Regardless of your condition, Medicare pays for up to a maximum of 12 weeks of care. They have very strict rules and limitations.
*After this you will receive a significant Medicare discount.
We simply need a copy of your Medicare card.
*Medicare supplements normally don't pay anything.

*Initial_____*