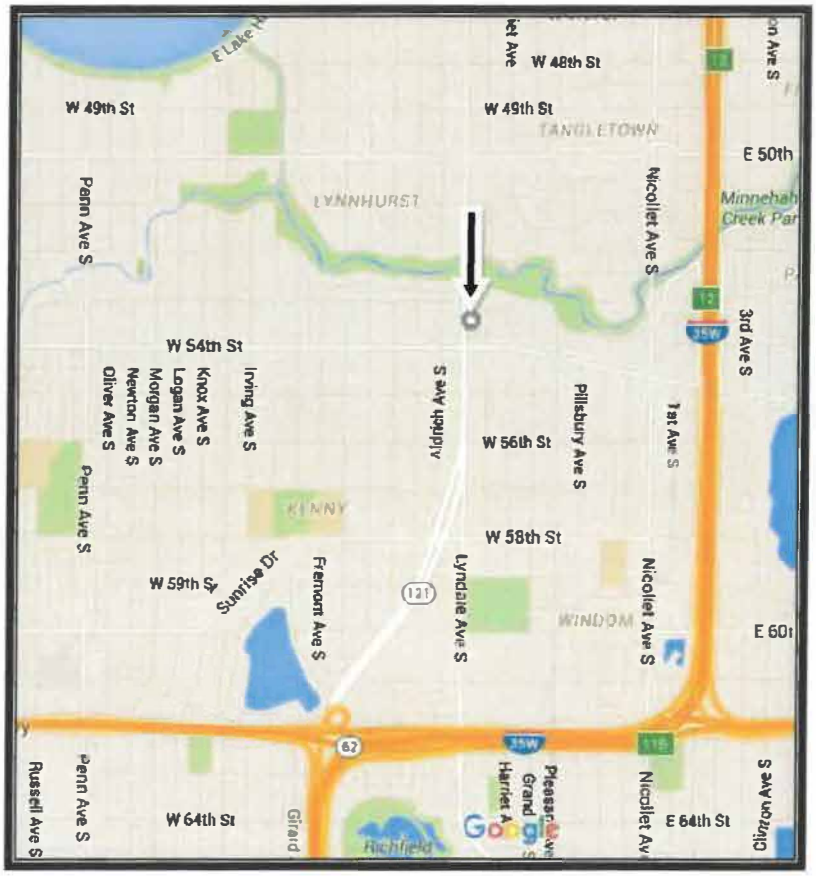
Nokomis Chiropractic & Wellness
Dr. Jonathan W. Olson
5313 Lyndale Avenue South Minneapolis, MN 55419
612-822-0149 www.NokomisChiropractic.com



Nokomis Chiropractic & Wellness is located, on Lyndale Avenue, between 53rd and 54th streets. We are in the same building as Prima and Subway just North of Kowalski's Market and South of the Washburn Library. To enter our office you will need to **park and enter from the back.**

If you are going South on Lyndale, turn left on 53rd Street and go approximately ½ block, (just past Mulberry's Cleaners) then turn right into the parking lot. Our office is located on the South end of the lot. When you enter the building we will be the first door on the left.

If you are going North on Lyndale, turn right on 54th Street and go one block to the light, which is Garfield. Turn left at Garfield and go to the 3rd driveway on your left...when you enter you will see our clinic directly in front of you.

We are on the main level and there is handicapped parking right outside the door.
If you need additional directions or assistance coming in from the parking lot,
please call us at 612-822-0149.

Meanwhile, we look forward to being of service.

PATIENT INFORMATION

ACCT#

Last Name _____ First Name _____ Middle Initial _____

Address _____ SS# _____ Birth Date _____ Age _____

City _____ State _____ Zip _____ Male ☐ Female ☐ Marital Status: S M W D Separated

Occupation _____ Health Insurance _____

Employer _____ Insurance/Policy # _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Email Address _____ Emergency Contact _____

Spouse Name _____ Phone# _____

Occupation _____ Relationship _____

Employer _____ Referred by _____

Children (Name/Age) _____

CURRENT COMPLAINTS

Please list your major complaints	How long have you had this problem?	Is it getting better (B) worse (W) or same (S)	Is it constant (CS) or comes & goes CG?
1) _____	_____	B W S	CS CG
2) _____	_____	B W S	CS CG
3) _____	_____	B W S	CS CG

Did your injury occur ☐ While at work? ☐ Motor vehicle accident?

Is this condition ☐ NEW ☐ OLD Was it treated before ☐ YES ☐ NO

If treated before, what was done? _____

Names of Doctors _____

Medications you currently take _____

PAIN LOCATION & TYPE

Using the codes below, please mark on the drawing to indicate where your pain is and what you are feeling.

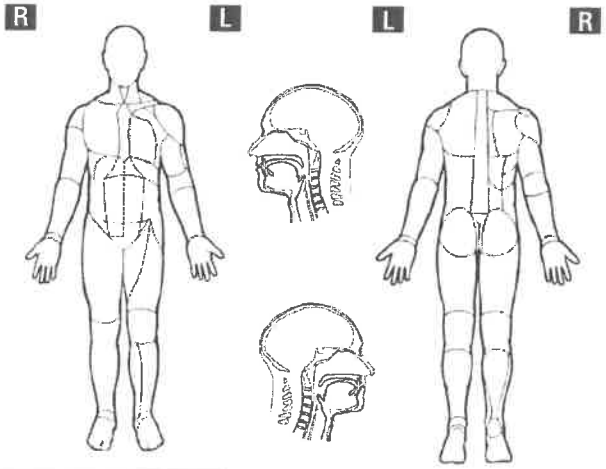
Sharp x x

Burning + +

Dull Pain √ √

Pins & Needles ○ ○

Numb ● ●



HEALTH HISTORY

From birth to present, please list by date and describe any car accidents, work-related, recreational, athletic or other injuries.

_____

_____

_____

_____

_____

Have you ever been hospitalized? ☐ YES ☐ NO

List any Surgeries

_____ _____

_____ _____

HEALTH STATUS REVIEW

Please check all current and past conditions, even if they don't seem related to your complaint.

☐ Neck pain	☐ Carpal Tunnel	☐ Thyroid problems
☐ Mid back pain	☐ Frequent colds	☐ Heart problems
☐ Low back pain	☐ Ear Infections	☐ High/low blood Pressure
☐ Headaches	☐ Sinus Problems	☐ Prostate problems
☐ Migraine	☐ Asthma	☐ Impotence
☐ Numb arms/hands	☐ Allergies	☐ Dizziness
☐ Numb legs/feet	☐ Ulcers/Colitis	☐ Depression
☐ Arthritis	☐ Constipation	☐ Loss of sleep
☐ General stiffness	☐ Diarrhea	☐ Diabetes
☐ Shoulder problems	☐ Eczema/Shingles	☐ Cancer
☐ Knee problems	☐ Fatigue/Tired	☐ Substance abuse

☐ Other _____

Women only: Do any of the following apply to you?

Pregnant? ☐ Yes ☐ No Painful periods? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No Irregular cycles? ☐ Yes ☐ No

Birth control? ☐ Yes ☐ No Breast implants? ☐ Yes ☐ No

CHIROPRACTIC EXPERIENCE

Have you ever had Chiropractic care before? ☐ YES ☐ NO

NAME OF DOCTOR	DATE
_____	_____
_____	_____

Date of last spinal X-rays or other X-rays _____

HEALTH CARE GOALS

Describe how your current health complaints interfere with the different areas of your life: Work, Family, Relationships, Sports, Hobbies, House work, etc.

_____

_____

When was the last time you felt your best? _____

On a scale of 1-10 (1 is low, 10 is high)

Where would you rate your overall health, including physical, mental, nutritional, stress and energy? _____

What level of overall health would you like to have? _____

_____ _____

Patient Signature **Date**

Last Name______________________ First_____________ Date__________ Account #_____________

Area of Complaint:____
When did it start?______________________________ Is it getting: worse better same
How did it start?____
How often? constant comes & go occasional other:___________________________
Describe the pain: sharp, dull, burning, throbbing, achy, numb, tight, pressure, tension, tingling, stiff, ROM
other: ____
Does the pain radiate?: yes no Where:______________________ Type of Pain: ______________________
Frequency: constant comes & goes other:______________________________
What makes it worse?:____
What makes it better?:____
Who else have you seen?:____
When it's at its worst on a scale of 1-10?_____________
Other:____
____

Area of Complaint:____
When did it start?______________________________ Is it getting: worse better same
How did it start?____
How often? constant comes & go occasional other:___________________________
Describe the pain: sharp, dull, burning, throbbing, achy, numb, tight, pressure, tension, tingling, stiff, ROM
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Does the pain radiate?: yes no Where:______________________ Type of Pain: ______________________
Frequency: constant comes & goes other:______________________________
What makes it worse?:____
What makes it better?:____
Who else have you seen?:____
When it's at its worst on a scale of 1-10?_____________
Other:____
____

Area of Complaint:____
When did it start?______________________________ Is it getting: worse better same
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Describe the pain: sharp, dull, burning, throbbing, achy, numb, tight, pressure, tension, tingling, stiff, ROM
other: ____
Does the pain radiate?: yes no Where:______________________ Type of Pain: ______________________
Frequency: constant comes & goes other:______________________________
What makes it worse?:____
What makes it better?:____
Who else have you seen?:____
When it's at its worst on a scale of 1-10?_____________
Other:____
____

FAMILY HISTORY

Family History: List any significant family health history by family member. (i.e. mother-high blood pressure)

Mother	Father	Sibling	Spouse	Children

SOCIAL HISTORY

Do you use and if yes, how much:

alcohol_____________ caffeine______________

illicit drugs_______ or tobacco products?_______

Do you exercise?______ How often?____________

Do you sleep well?_____ How many hours?______
Any Allergies?______________________________

Describe your diet___________________________

____

____

Last Name: _____ **First Name** _____ **Account #:**_____

PATIENT HEALTH INFORMATION CONSENT FORM (HIPAA)

I agree to the policies and procedures of the Nokomis Chiropractic Center P.A. Patient Health Information Consent Form, a copy of which has been made available for me at the front desk. All "individually identifiable health information" held or transmitted by Nokomis Chiropractic Center P.A. and its business associates, in any form or media, whether electronic, paper, or oral are covered under these privacy protections. I understand that my consultation, and doctors review of findings may be recorded or videotaped for the purpose of doctor co-management and internal training purposes only.

AUTHORIZATION FOR CARE and INFORMED CONSENT

I hereby authorize the Doctor(s) and staff of Nokomis Chiropractic Center P.A. to evaluate and treat my condition as deemed appropriate. I have been informed that all forms of health care, including chiropractic, have possible side effects including stiffness, soreness and certain rare to extremely rare risks including rib fractures, vascular dissection or death.

I understand that if the Doctor does accept my case, it does not guarantee or imply a guarantee of being able to cure or prevent any condition, illness or injury.

PATIENT COMMUNICATION

I agree to receive text and e-mails from Nokomis Chiropractic and Wellness for my appointment reminders, newsletters and other educational or incentive opportunities. I understand I will have the option to opt-out of each category as I choose. Message & data rates may apply.

FINANCIAL/INSURANCE AGREEMENT

At Nokomis Chiropractic Center P.A., we accept most insurance plans and offer cash payments options. We will happily check your benefits and directly bill the insurance company for services covered per your policy with the following understanding.

I clearly understand insurance verification and authorization is not a guarantee of payment and that I am responsible for all services rendered including but not limited to: deductibles, co-payments, non-covered or denied services rendered, vitamins, supplements and durable goods. I authorize Nokomis Chiropractic Center P.A. to release my information to the insurance company in an effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance reimbursements. If care is suspended or terminated for any reason, any outstanding balance will become immediately due and payable.

Who should receive bills for payment on my account?

___Patient___Spouse___Parent___Worker's Comp___Auto Insurance___Medicare___Medicaid___Health Insurance

If insurance: Name of Primary Insured_____ Primary's Date of Birth_____Relationship_____

Address of Primary Insured: Same or _____

_____ _____ _____ _____

Patient Signature _____ Date _____ Parent or Guardian _____ Date_____

X-RAY CONSENT

X-rays can be a necessary part of your overall evaluation. I consent to receive the x-rays recommended by the Doctor.

_____ _____ _____ _____

Patient Signature Date Parent or Guardian Authorizing Care Date

FEMALE PATIENTS ONLY Please check the appropriate statement:

_____I am not pregnant and consent to the x-rays recommended by the doctor.
_____I could be pregnant and would like to wait until I am sure before having x-rays taken.
_____I am pregnant.