John D. Belde, DC
Jonas T. Johnson, DC
Kelley McGowan, PT
211 Hwy 25, P.O. Box 717
Monticello, MN 55362
763.295.4105

BELDE CHIROPRACTIC & body shop

Date _____

Patient General Information

Name_____ Date of Birth _____ Gender_____
Address_____ Social Security No._____
City/State_____ Zip_____
Marital Status: M S Spouse's Name_____
Phone Numbers: (home)_____ (work)_____ (cell)_____
Would you like to receive information via e-mail: Y N Email Address_____
Employment: □ employed: full-time/part-time Employer: _____
□ student □ retired _____

Emergency Contact:_____ Relation:_____
Phone: _____

How were you referred to Belde Chiropractic and body shop?_____

Payment Information

□ Cash (payment due at time of service)
□ Insurance (please provide card for copying) Do you have a supplemental insurance? Y N
Person Providing Insurance (the insured): Self Spouse Parent
If other than self: Name_____ Date of Birth _____
Address (if different from above)_____
Employer_____
□ Auto Accident/Work Injury (additional information required)

Authorization & Assignment

I authorize Belde Chiropractic Clinic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me.

I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.

I understand that whatever amounts you do not collect from insurance proceeds (whether it be all or part of what is due) I personally owe you.

I, the undersigned do hereby appoint Belde Chiropractic Clinic authority necessary to endorse and cash any checks, drafts or money orders which are made payable to the undersigned or as co-payee with this clinic when said payments are due to services rendered on behalf of the undersigned by the clinic.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

Date:_____ **Patient or Guardian's Signature:**_____

Informed Consent

I hereby authorize physicians at Belde Chiropractic Clinic to treat my condition as deemed appropriate. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Belde Chiropractic responsible for any errors or omissions that I may have made in the completion of this form.

Chiropractic, as well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

Date:_____ **Patient's Signature:**_____

Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgement.

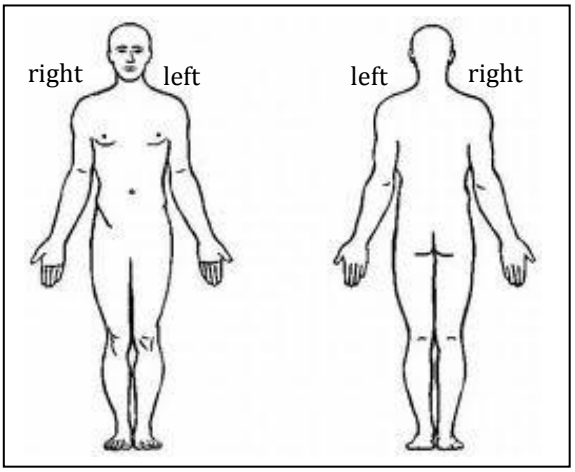
I, _____, have received a copy of this office's Notice of Privacy Practices.
Print Name

Date:_____ **Patient's Signature:**_____

Name:_____ Date:_____

Reason for This Visit

What is your major complaint(s)?_____
When did this symptom(s) begin?_____
If this is an injury, describe what happened._____
_____
Place "X"s on the area(s) where you have pain and draw lines to show where the pain radiates.



Have you experienced these symptoms before? Y N When?_____
What aggravates this condition?_____
What decreases the symptoms/pain?_____
Have you seen another doctor for this condition? Y N
Doctor's name:_____ Date consulted:_____ Diagnosis:_____
Does this condition interfere with your sleep? Y N
If so, how many times do you wake up in pain per night?_____
In what position do you sleep? Back Side Stomach
Do you sleep with a pillow? Y N If Yes, how many?_____
Does heat affect the pain? Y N If Yes, how?_____
Does cold affect the pain? Y N If Yes, how?_____
Do you now or have you ever worn foot orthotics or a heel lift? Y N If Yes, which side? R L
Does it cause pain to cough, grunt, or sneeze? Y N If so, where?_____

Check those activities below during which you experience difficulty or pain.

○ Lying on back	○ Getting in/out of car	○ Pulling	○ Sitting	○ Standing for long periods
○ Lying on side	○ Dressing Self	○ Reaching	○ Bending forward	○ Sneezing
○ Turning over in bed	○ Sexual Activity	○ Kneeling	○ Bending backward	○ Coughing
○ Lying on stomach	○ Pushing	○ Stooping	○ Walking	○ Other

Please check all additional complaints that you have at this time:

O Loss of Concentration	O Neck Pain/Stiffness	O Shortness of Breath	O Cold Hands	O Arthritis
O Eyes Sensitive to light	O Upper BackPain/ Stiffness	O Irritable	O Cold Feet	O HIV (Aids)
O Memory Loss	O Mid Back Pain/ Stiffness	O Anxiety	O Jaw Pain	O Other (Please List)
O Heavy Feeling of Head	O Right/ Left Shoulder Pain	O Depression	O Hypertension	
O Dizziness	O Right/ Left Arm Pain	O Insomnia	O Diabetes	
O Ringing in Ears	O Low Back Pain/Stiffness	O Fatigue	O Convulsions	O Numbness
O Loss of Balance	O Pins & Needles Arms/Legs	O Excess Perspiration	O Allergies (list)	
O Loss of Smell	O Right/ Left Leg Pain	O Digestive Trouble		O Swelling
O Loss of Taste	O Vision Problems	O Nausea		
O Pain Behind Eyes	O Sinus Trouble	O Vomiting	O Cuts	O Bruising
O Fainting	O Nervousness	O Diarrhea		
O Palpation	O Chest Pain	O Constipation	O Heart Disease	O Anemia

Do you have, or have you ever had, any diseases or medical problems not listed? Yes No

If so, please list:_____

Fill out the next sections as they apply to you.

Low Back Pain

Does pain radiate into the leg? Y N Where:_____

Does pain radiate to the abdomen? Y N

Do you ever have impairment of bowel or urinary function? Y N

Explain:_____

Do you have numbness or tingling into the legs? Y N

Explain:_____

Neck Pain

Does pain affect: hearing vision balance ringing in ears

Do you hear grating sounds? Y N

Do you feel pressure behind your eyes? Y N

Does pain radiate into the arm? Y N

Do you have difficulty lifting or turning your head? Y N

Explain:_____

Headaches

Do you get headaches? Y N Frequency_____

Do you have a family history of headaches? Y N

Along with your headaches do you experience:

pain or cracking in jaw nausea visual disturbances

abnormal blood pressure vomiting

When was your last eye exam:_____

If female, are you pregnant? Y N Not sure Date of your last menstrual period:_____

Name:_____ Date:_____

List all medications you are taking now, including over the counter medication.

_____
_____
_____
_____
_____
_____

Are you allergic to any medications? Please list._____

List all hospitalizations and surgeries.

_____
_____
_____
_____
_____

Have you seen a chiropractor before? Y N If yes, when:_____

Were x-rays taken?_____

Name/Address/City_____

Do you have a family physician? Y N

Name/Address/City_____

Any additional information you would like the doctor to know about before beginning care at Belde Chiropractic and body shop:_____

_____
_____

Family History

Please indicate if anyone in your family currently has or has in the past suffered from any of the conditions listed below:

□ Arthritis, whom:_____
□ Back Pain, whom:_____
□ Cancer, whom:_____
□ Diabetes, whom:_____
□ Heart Disease, whom:_____
□ High Blood Pressure, whom:_____
□ High Cholesterol, whom:_____
□ Osteoporosis, whom:_____
□ Stroke, whom:_____
□ Thyroid Conditions, whom:_____

Name:_____ Date:_____

Social History

Alcohol use:	□ Daily	□Weekly	How much?_____
Coffee use:	□ Daily	□Weekly	How much?_____
Tobacco use:	□ Daily	□Weekly	How much?_____
Exercising:	□ Daily	□Weekly	How much?_____
Pain Relievers:	□ Daily	□Weekly	How much?_____
Soft Drinks:	□ Daily	□Weekly	How much?_____
Water Intake:	□ Daily	□Weekly	How much?_____

Recreational Drugs:	□ Yes	□ No
Vaccinations:	□ Yes	□ No
Mercury Fillings:	□ Yes	□ No
Job pressure/stress:	□ Yes	□ No

Name:_____ Date:_____

To be completed ONLY if Automobile Related

Date of Collision:_____ Hour_____ AM PM Location:_____

Please describe the collision:_____

_____

_____

Were you: O Driver O Passenger O Pedestrian Do you own the vehicle? O Yes O No

What type of vehicle? _____

Were you struck from: O Behind O Right Side O Left Side O Front O In park

Collision details:

Did your car strike the other(s) involved? O Yes O No

Did the other car strike yours? O Yes O No O Undetermined

Describe the other vehicle._____

Did your vehicle's airbags deploy? O Yes O No

Were you wearing a seat belt? O Yes O No

Did your head (or any other body part strike the inside of the vehicle? O Yes O No

At the time of impact, what direction were you looking?_____

Did you lose consciousness at any time?_____

What did you feel immediately after the collision._____

_____

Where did you go after the collision._____

Have you received any treatment for your condition? O Yes O No

If yes, name/phone number of provider._____

Were x-rays taken?_____

Were any medications prescribed?_____

What were the recommendations given for care?_____

_____

Have you had similar symptoms in the past? O Yes O No

Are you presently unable to perform any social/recreational or work activities because of your injuries? O Yes O No If yes, please describe._____

_____

Are you covered by Medicare? O Yes O No

If under 18 years old, name/relationship of guardian._____

Do you have an attorney who has advised you in this case? O Yes O No

Attorney Name:_____

Attorney's Address:_____

Patient's Auto Insurance Information in addition to copy of insurance card.

Insurance company name/address._____

Claim adjuster: _____ Claim number: _____

_____Doctor's Initials

Name:_____ Date:_____

To Be Completed ONLY if Injury is Work Related

Employer Name_____
Employer Address_____
Employer Phone_____

Date of Accident:_____ Hour_____ AM PM Location:_____

Please describe the accident:_____
_____
_____

Did you report the injury to your foreman or employer? O Yes O No
Name/Position_____
What did you feel immediately after the accident?_____
_____
What are your present complaints?_____
_____
When did your problems first start?_____
Were you taken anywhere after the accident? O Yes O No
Where:_____
What was done for you?_____
_____
Have you seen any other doctors for this condition?_____

Have you had similar symptoms in the past? O Yes O No

Are you presently unable to perform any social/recreational or work activities because of this accident? O Yes O No If yes, please describe._____
_____

What type of work do you do?_____
Has work aggravated your condition? O Yes O No

Are you covered by Medicare? O Yes O No

If under 18 years old, name/relationship of guardian._____

Do you have an attorney who has advised you in this case? O Yes O No
Attorney Name:_____
Attorney's Address:_____