



Patient Information

Genesis Chiropractic Health Center p.1
4678 Slater Rd Eagan, MN 55122 651-905-0330

Name _____ Today's Date: _____ DOB: _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Cell: (____) _____ Work: (____) _____ Gender M F Married: Yes or No
 Significant Other's Name _____ Children Names/Ages _____
 Employer _____ Type of Work _____
 E-Mail Address: _____ Have you been to a chiropractor before? No Yes
 Preferred Method of contact: Home Cell Work Email
 Emergency Contact _____ Phone # _____

Most patients are referred to us by a caring family or friend, who can we thank? _____

- I authorize the doctor and or staff to render care as deemed appropriate for me and /or my child.
- I authorize the release of 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 this provider.
- Person responsible for this account if other than the patient? _____

I understand that after initial promotional services all care is rendered at usual and customary fees.
 For my balance my preferred payment method is: Cash Check Credit Card Auto/Work Ins.

 Patient / Parent Signature (This represents authorization for all occasions of services) Date

Health Concerns

Please list concerns in order of importance:

1. _____ How long has this been an issue? _____
 Is it: Dull Sharp Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Pain radiates to _____
 2. _____ How long has this been an issue? _____
 Is it: Dull Sharp 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 Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Pain radiates to _____

Does your condition affect: Sleep Work Leisure Sports Daily Routines

How did your symptoms begin? _____
 What IMPROVES concern #1? _____
 What makes concern #1 WORSE? _____
 Have you seen other specialists? _____
 Types of treatment: _____

Work activity (circle): Sitting, Standing, Light Labor, Heavy Labor

DOCTOR NOTES: _____

Please mark All Areas of Concerns



Any surgeries/or hospitalizations? _____
 Are you pregnant? Yes No Expected Due Date: _____
 Auto or Work injuries can cause serious Subluxations. Is your visit related to a Auto or Work injury? Yes No
 If Yes, Date of Accident? _____ please inform CA so they can provide with necessary paperwork.
 Was claim opened Yes No Was care received? Yes No Attorney (if applicable) _____
 List any past work, sports or recreational injuries _____
 Mark health conditions that apply to you & Medications you're taking _____

- | Past | Present | Past | Present |
|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Leg / Foot Numbness | <input type="checkbox"/> | <input type="checkbox"/> Kidney/Gall Bladder Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Fibromyalgia or Chronic Fatigue | <input type="checkbox"/> | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> Medication Side Effects | <input type="checkbox"/> | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> Trouble Walking | <input type="checkbox"/> | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> | <input type="checkbox"/> Allergies / Asthma | <input type="checkbox"/> | <input type="checkbox"/> Blood Thinner use |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> HIGH____ or LOW____ Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> | <input type="checkbox"/> Stroke History |
| <input type="checkbox"/> | <input type="checkbox"/> Depression | <input type="checkbox"/> | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> | <input type="checkbox"/> Pain in <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Back |
| <input type="checkbox"/> | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> | <input type="checkbox"/> Pain in <input type="checkbox"/> Foot/ankle <input type="checkbox"/> Knee <input type="checkbox"/> wrist |
| <input type="checkbox"/> | <input type="checkbox"/> TMJ | <input type="checkbox"/> | <input type="checkbox"/> Heart Pacemaker/Heart Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> | <input type="checkbox"/> Visual Problems | <input type="checkbox"/> | <input type="checkbox"/> UTI <input type="checkbox"/> Prostate Problems |
- Health and Wellness Goals: _____

Wellness History

A. Stress may cause or accelerate spinal damage. Using a scale 1-10 (1=none, 10=extreme).
 Rate stress levels in past 90 days: Occupational _____ Personal _____
 B. Poor posture leads to poor health and may indicate spinal problems. How would you rate your posture?
 Poor 1 2 3 4 5 6 7 8 9 10 Excellent
 C. Rate your habits regarding the following (1=poor - 10=Excellent):
 Eating _____ Body Weight _____ Exercise _____ Sleep _____ Energy _____ Digestion _____ Overall Wellness _____
 List activities you enjoyed but now is difficult to perform due to subluxations? _____

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 _____
 Other family conditions: _____