Robert R. DeYoung, D.C. Maudie R. Louisiana, D.C.

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Patient name:_____ Today's Date: ____/____/____
First Name, Middle Initial, Last Name

Address:_____ Date of Birth: ____/____/____ Age:_____

City:_____ State:____ Zip:_____ Social Security Number:_____

Phone numbers: (check best day-time contact method) Employer:_____

☐ Home: _____ Occupation:_____

☐ Cell: _____ How did you find out about this office?_____

☐ Work: _____

☐ Email: _____

Emergency Contact:_____

Relationship to you:_____

Phone number:_____

Spouse / Partner's Name:_____ Number of Children, if any:_____

Date of Birth: ____/____/____ Age:_____

Employer:_____

Spouse/Partner's Employer:_____

Spouse/Partner's Occupation:_____

Describe the health of your spouse/partner:_____

Name of Child(ren)	Age	Current Health Problems?

Insurance: (the front desk will take a copy of your card(s) **including any secondary insurance**)

If you are under someone else's insurance policy, please fill in this information:

Name of Insured:_____ Insured's Date of Birth: ____/____/____

Insured's Address:_____ Insured's Phone #:_____

City:_____ State:_____ Zip:_____

Insured's Employer:_____

What health problems are you struggling with? How long?

1._____ _____

2._____ _____

3._____ _____

Are you in pain? If so, please rate 1-10. _____

What have you tired to make the situation better? Did it help?

1._____ Yes/No/Somewhat

2._____ Yes/No/Somewhat

3._____ Yes/No/Somewhat

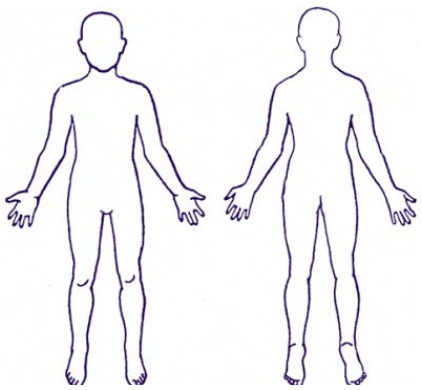
Is it a Work Injury (Yes / No) or Car Accident Injury (Yes / No)

Please list the name(s) of the doctor(s) or therapist(s) you have seen for this:_____

_____

Please indicate where your symptoms are located:

Front Back



Have you even been adjusted? (Yes / No)

If yes, when last?_____

Do you have a preference on which doctor treats you?

☐ I have no preference ☐ Dr. De Young ☐ Dr. Louisiana

What are your goals for treatment?

1._____

2._____

3._____

Would you like to integrate other services into your care? What would you be interested in learning more about?

☐ Chiropractic ☐ Spinal Rehab

☐ Mind / Body Medicine ☐ Nutritional Therapy

☐ Inflammation Management ☐ Massage Therapy

☐ Hormone Evaluation / Therapy ☐ Acupuncture

List any car accidents, work injuries, recreational, sports or childhood injuries including all broken bones and stitches.

_____ _____ _____

_____ _____ _____

List any hospitalizations or surgeries you have had (including C-Section).

_____ _____ _____

_____ _____ _____

List all current medications and supplements.

_____ _____ _____

_____ _____ _____

List any known allergies.

_____ _____ _____

_____ _____ _____

BASIC HEALTH REVIEW:

1. How much stress do you experience on a scale of 0 – 10 (10 = highest)? _____/10
2. Do you feel that you have the skills to cope with stress well (Yes / No)
3. Do you take deep breaths when you are stressed, focus on something pleasant? (Yes / No)
4. Do you drink the equivalent of eight 8-ounce glasses of water a day? (Yes / No)
5. How many hours of sleep do you get per night? _____ Would you consider it quality sleep? (Yes / No)
6. How often during the week do you get moderate physical activity? _____ times/week
7. Do you eat a diet HIGH in vegetables, fruits, whole grains, low-fat dairy, chicken and fish while LIMITING red meat, sugar, high fructose corn syrup, trans fats and processed food? (Yes / No)
8. Do you read nutritional labels and understand what they mean? (Yes / No)
9. Do you supplement with Omega-3s, Vitamin D3 and a quality multi-vitamin (not a "One-a-Day")? (Yes / No)
10. If you have children, do you teach them what you know about health and having a healthy lifestyle? (Yes / No)

FAMILY HISTORY Please indicate who, in your family, had the following conditions (M=Mom, D=Dad, B=Brother, S=Sister)

_____ Cancer	_____ Diabetes	_____ Heart Attack	_____ High Blood Pressure
_____ Lung Disease	_____ Mental Illness	_____ Multiple Sclerosis	_____ Rheumatoid Arthritis
_____ Stroke	_____ Thyroid Disease	_____ Ulcer/Digestive Issues	

ACTIVITIES OF DAILY LIVING

Check each of the activities which you have difficulty performing or which cause pain when performing.

☐ Bending	☐ Chewing	☐ Climbing Stairs	☐ Driving	☐ Getting in & out of car
☐ Kneeling	☐ Laying in Bed	☐ Lifting	☐ Reading	☐ Riding (passenger)
☐ Running	☐ Sexual intercourse	☐ Sitting	☐ Sleeping	☐ Standing
☐ Swimming	☐ Using a computer	☐ Walking	☐ Sports (List:_____	

☐ Other_____

REVIEW OF SYSTEMS (Check ones that you have now or have had in the past)

Now	Past		Now	Past		Now	Past	
General			**Gastrointestinal**			☐	☐	Muscle pain
☐	☐	Fatigue	☐	☐	Abdominal pain	**Neurologic**		
☐	☐	Troubled sleep	☐	☐	Acid reflux	☐	☐	Difficulty with speech
☐	☐	Weakness	**Genitourinary**			☐	☐	Dizziness
☐	☐	Weight gain	☐	☐	Sexual problems	☐	☐	Hand trembling
☐	☐	Weight loss	**Head**			☐	☐	Lack of coordination
Breast			☐	☐	Headache	☐	☐	Loss of facial expression
☐	☐	Breast changes	☐	☐	Head injury	☐	☐	Loss of sensation
Cardiovascular			☐	☐	Neck pain	☐	☐	Numbness
☐	☐	Chest pain or pressure	**Mental Health**			☐	☐	Paralysis
Ear/Nose/Throat			☐	☐	Alcoholism	☐	☐	Seizures
☐	☐	Ringing in ears	☐	☐	Drug addiction	☐	☐	Tingling
☐	☐	Decreased hearing	☐	☐	Drug dependency	☐	☐	Vertigo
Eyes			☐	☐	Depression	**Respiratory**		
☐	☐	Cataracts	☐	☐	Extreme worry	☐	☐	Cough
☐	☐	Changing vision	☐	☐	Insecurity	☐	☐	Wheezing
☐	☐	Glaucoma	☐	☐	Irritable	☐	☐	Painful breathing
Endocrine			☐	☐	Loss of memory	**Women Only**		
☐	☐	Change in appetite	☐	☐	Suicidal thoughts	☐	☐	Birth control
☐	☐	Cold intolerance	**Musculoskeletal**			☐	☐	Irregular periods
☐	☐	Heat intolerance	☐	☐	Joint pain	☐	☐	Nursing
☐	☐	Sweating	☐	☐	Joint stiffness	☐	☐	Painful periods
☐	☐	Thirst	☐	☐	Muscle cramps	☐	☐	PMS

PAST MEDICAL HISTORY (Check any that you have had in the past)

☐ Alcoholism	☐ Epilepsy/seizures	☐ Hepatitis	☐ Migraine	☐ Rheumatic fever
☐ Allergies	☐ Gallstones	☐ Hypertension	☐ Mumps	☐ Sexual problems
☐ Angina	☐ Glaucoma	☐ Intestinal polyps	☐ Nervous breakdown	☐ Skin trouble
☐ Arthritis	☐ Gonorrhea	☐ Jaundice	☐ Paralysis	☐ Stroke
☐ Bladder trouble	☐ Gout	☐ Kidney infection	☐ Parasites	☐ Thyroid problems
☐ Blood disease	☐ Heart murmur	☐ Kidney stones	☐ Phlebitis	☐ Tumor
☐ Depression	☐ Heart trouble	☐ Liver trouble	☐ Polio	☐ Ulcers
☐ Diabetes	☐ Hemorrhoids	☐ Mental illness	☐ Prostate problem	☐ Varicose veins

☐ Cancer (specify type and location)_____

IMMUNIZATIONS (Check any that your have had in the past)

☐ Chicken Pox	☐ HPV	☐ Measles	☐ Mumps	☐ Polio	☐ Tetanus
☐ DPT	☐ Influenza	☐ MMR	☐ Pneumococcal	☐ Smallpox	☐ Typhoid

☐ I choose not to be immunized

LIFESTYLE (How much do you use per day?)

Tobacco _____ cigarettes or cigars or chew

Alcohol _____ cocktails or beers or glasses of wine

Caffeine _____ cups of coffee or tea or sodas

Exercise _____ minutes of light / moderate / intense (circle one)

I certify by signing this, that I have filled this form out to the best of my ability, recalling all of my past medical history, and otherwise making the doctor fully aware of any and all pre-existing conditions.

Signature:_____ Date:_____

Initial

X-RAY RELEASE FORMS (ADULT)

_____ Dr Louisiana and Dr. De Young have explained that the purpose of the x-rays about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness of chiropractic spinal adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing this x-ray, I will be informed. I then must determine if I should seek the services of an additional health care provider for advice, diagnosis or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation corrective care provided by this office. The above named doctor and whomever they designate as their assistant(s) have my permission to x-ray me for diagnostic interpretation. I understand that the fee for treatment x-rays is the analysis only and the film itself is the legal property of Your Life Chiropractic, P.A.

_____ In accordance with the Minnesota State Department of Health Regulation, Chapter 4730.1510 Subp. 7. Gonad Protection, "Except in cases in which it would interfere with the diagnostic procedure during radiographic procedures in which the gonads are in or within two inches o the useful beam, gonad shielding of not less than 0.5 millimeter lead equivalence must be used fore patients who have full procreative potential."

As a chiropractor, I will be doing a thorough assessment of your spine which includes full spine x-rays. I do not use gonad shielding with these x-rays because it obscures a portion of the pelvis that I want to view, unless you request me to do so. By signing this consent form, I am in agreement with the diagnostic procedures Dr. Louisiana and Dr. De Young use.

_____ **FOR FEMALES ONLY**: To the best of my knowledge I am NOT pregnant and do not suspect that I am pregnant.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

_____ I understand that, under the Health insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read and understand your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the NOTICE OF PRIVACY PRACTICES from time to time and that I may contact them at the address below to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used to disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

_____ I request payment of authorized benefits directly to the provider for services furnished to me at Your Life Chiropractic. I consent to the release of medical and other information related to such services for healthcare operations and to Medicare, my insurance company, HMO, other third party payers, or their third party administrators, in order to process and pay claims, determine benefit and perform quality of care reviews.

_____ I agree to pay for any charges not covered by my insurance.

Patient Name:_____

Patient Signature:_____ Date:_____