Family Chiropractic Clinic
Optimal Health Nutrition Center

Chiropractic and Nutritional Treatments
Dr. Mark A. Pederson
Chiropractor & Clinical Nutritionist
603 North Main Street Warren, MN 56762 (218) 745-6655
www.optimal-health.co info@optimal-health.co

Chiropractic Intake Form:

Greetings and thank you for contacting our office regarding your health concerns:

Enclosed you will find your intake paper work. Please complete in full and return to our office prior to your appointment if you have been instructed to do so. Otherwise, please bring completed forms with to your appointment. A checklist of necessary items is listed below. **Please see that all are complete prior to your consultation visit.** Thank you.

Checklist of items to be completed for consultation visit:

- Patient Information Packet
- Medical Records
  - If you have had lab work/x-ray/MRI/CT evaluations for this condition within the last six (6) months, please bring a copy of the reports with you to your appointment..
- Typed/Written History of Health Concern(s) at end of this packet
  - Please complete the typed/written history of your health concern (s) form enclosed.
- You Must Bring Shorts and T-Shirt with you to your appointment.
  - You will be asked to change into this for your neurological evaluation.

Please also note that it is strongly recommended that spouses attend the consultation and evaluation appointment.

NOTE: If the patient is your child it is mandatory that a parent attend the consultation and evaluation appointment.

PATIENT INFORMATION:

Title: __Dr. __Miss __Mr. __Mrs. __Ms.
First: _____
Middle Initial: ____
Last: _____
Preferred Name: _____
Sex: __Male __Female
Date of Birth: _____
Social Security #: _____

Street: _____
City: _____
State: _____
Zip: _____

Marital Status: __Single __Married __Widowed __Separated __Divorced
Spouse Name: _____
Spouse Birthdate: _____
Spouse Occupation: _____
Spouse Employer: _____

PLEASE NOTE**: In order to better serve you we utilize text messaging to remind you of your scheduled appointment.**

Home Phone: _____ Work Phone: _____
Cell Phone: _____ Cell Phone Carrier:_____
Does your plan include text messaging? __ Yes __No
Does your plan include email messaging? __ Yes __No

PLEASE NOTE**: In order to better serve you we utilize email messaging to remind you of your scheduled appointment.**

Email: _____

Referred To Our Office By: _____

Emergency contact information:
Name: _____Relationship:_____
Phone 1: _____ Phone 2: _____

Employment:
Your employment status:
__Employed __Employed Part-time __Retired __Part-time student __Full-time student
Employer: _____

- Address: _____ Phone #:_____
- City: _____ State_____ Zip: _____

Occupation: _____
Type of Work: __Office/Clerical __Light labor __Moderate labor __Heavy labor

INSURANCE INFORMATION:
Has your insurance changed since your last visit? __Yes __No
Please bring your insurance card with you to your appointment.
Insurance Company: _____
Group Number: _____
Who is responsible for this account? _____
Relationship to patient: _____
Is patient covered by additional insurance? _____Yes _____No
Subscribers name: _____
Birthdate: _____
SS #: _____
Relationship to patient: _____
Insurance company: _____
Group #: _____

Assignment and Release:
I certify that I, and/or my dependent(s) have insurance coverage with
_____
(name of insurance company)
And assign directly to Dr. Mark Pederson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Mark Pederson may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Date:_____
Signature of patient, parent, guardian or personal representative

_____Date_____
Printed name of patient, parent, guardian or personal representative

PATIENT CONDITION:

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint #1 (reason you are here):

1. _____

Previous treatment for this complaint?_____

When did your complaint first begin?_____

Have you ever experienced this complaint before? _____

What makes your problem better?_____

What makes your problem worse?_____

Describe the type of pain/symptom you experience?_____

_____

Does your problem travel into any other part of your body? Where? _____

Where exactly is the complaint area?_____

When do you notice the problem?_____

Have you lost control of any body part (arms, legs, bladder, bowel, etc.)?_____

Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden? _____

Other complaints or problems:

1. _____
2. _____
3. _____

Current medications/drugs being taken:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

Medical doctors or other health care professionals you have consulted with in the last 12 months?

1. _____
2. _____
3. _____
4. _____
5. _____

Nutritional supplements you are taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Do you smoke, drink coffee or alcohol? (If yes indicate how much)

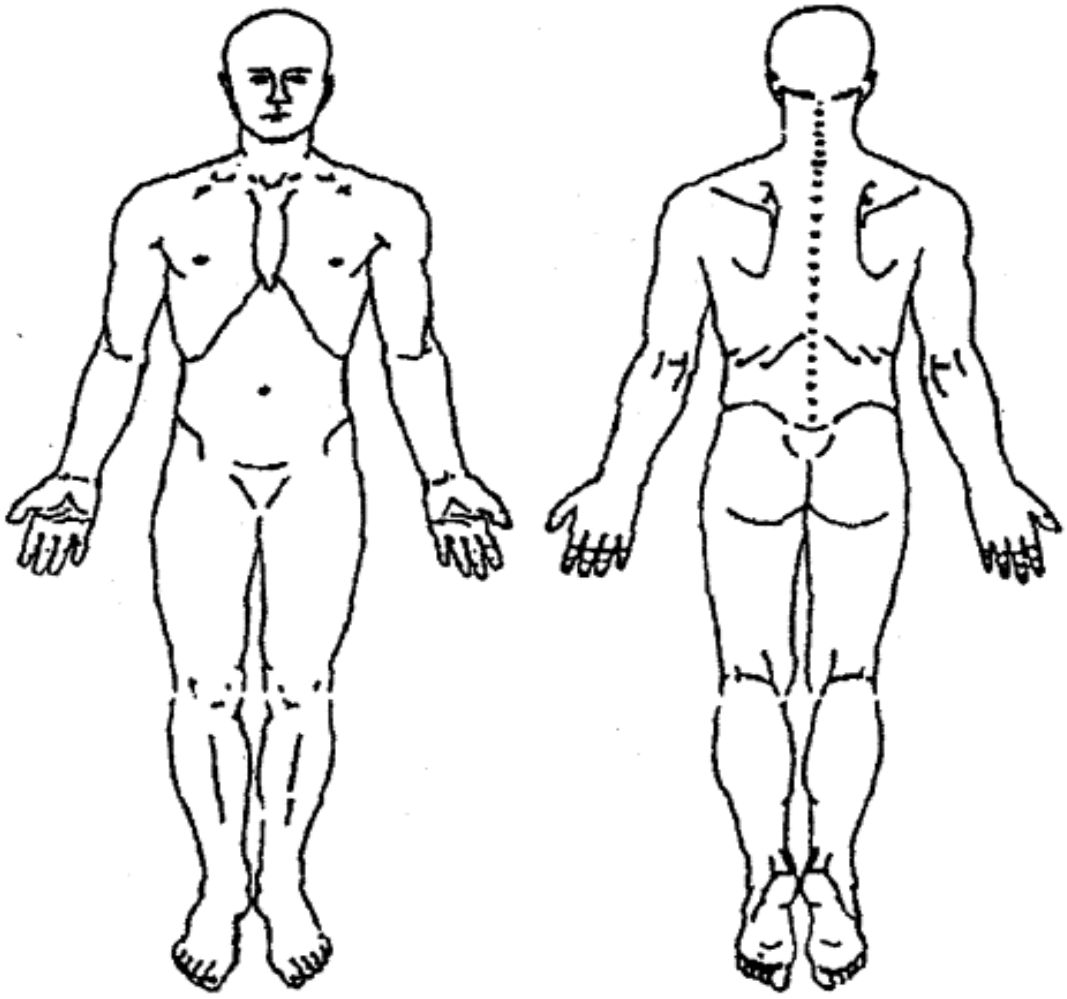
Cigarettes _____ Coffee _____ Alcohol _____

NAME:_____ DATE:_____

PAIN DRAWING

Using the symbols given below, mark the area on you body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
ΔΔΔΔ	=====	OOOOO	XXX	/////	.....



Please check off the following that apply to you:

Digestive Track:
- ❑ Nausea and vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Bloated feeling
- ❑ Stomach pains/cramps
- ❑ Heart burn
- ❑ Blood/mucous in stools

Ears:
- ❑ Itchy ears
- ❑ Ear aches/ear infections
- ❑ Drainage from ears
- ❑ Ringing in the ears
- ❑ Hearing loss
- ❑ Reddening of ears

Emotions:
- ❑ Mood swings
- ❑ Anxiety/fear/nervousness
- ❑ Argumentative
- ❑ Frustrated/cries easily
- ❑ Depression

Eyes:
- ❑ Watery/itchy eyes
- ❑ Red/swollen/eyelids
- ❑ Bags/dark circles under eyes
- ❑ Blurred or tunnel vision

Head:
- ❑ Headaches
- ❑ Faintness
- ❑ Dizziness
- ❑ Insomnia/sleep disorder
- ❑ Facial flushing

Heart:
- ❑ Irregular/skipped heartbeat
- ❑ Rapid/pounding heartbeat
- ❑ Chest pain

Joints:
- ❑ Pain/ache in joints
- ❑ Arthritis/osteoarthritis
- ❑ Stiffness/limited movement
- ❑ Pain/aches in muscles
- ❑ Feeling weak/tired
- ❑ Swollen/tender joints
- ❑ Growing pains in joints
- ❑ Psoriatic/gouty arthritis
- ❑ Rheumatoid arthritis

Lungs:
- ❑ Chest congestion
- ❑ Asthma/bronchitis
- ❑ Shortness of breath
- ❑ Difficulty breathing
- ❑ Persistent cough
- ❑ Wheezing

Mind:
- ❑ Poor memory
- ❑ Difficulty completing projects
- ❑ Difficulty with mathematics
- ❑ Underachiever
- ❑ Poor/short attention span
- ❑ Confusion
- ❑ Easily distracted
- ❑ Difficulty making decisions
- ❑ Learning disabilities

Mouth and Throat:
- ❑ Chronic coughing
- ❑ Gagging/clearing throat
- ❑ Sore throat/hoarse voice
- ❑ Swollen/discolored tongue
- ❑ Canker sores recurrent
- ❑ Itching on roof of mouth

Nose:
- ❑ Stuffy nose
- ❑ Chronically red/inflamed nose
- ❑ Sinus problems
- ❑ Hay fever
- ❑ Sneezing attacks
- ❑ Excessive mucous formation

Skin:
- ❑ Acne
- ❑ Itching
- ❑ Hives/rash/dry skin
- ❑ Hair loss
- ❑ Flushing/hot flashes

Weight:
- ❑ Binge eating/drinking
- ❑ Craving certain foods
- ❑ Excessive weight
- ❑ Compulsive eating
- ❑ Water retention

Genitourinary:
- ❑ Frequent illness
- ❑ Frequent/urgent urination
- ❑ Genital itch/discharge
- ❑ Anal itching
- ❑ Kidney problems
- ❑ Urinary tract infections
- ❑ Bladder problems
- ❑ Yeast infections

Other Conditions:
- ❑ Autism
- ❑ ADD
- ❑ ADHD
- ❑ Psoriasis
- ❑ Eczema
- ❑ Auto immune disorder
- ❑ Chronic fatigue
- ❑ Multiple chemical sensitivities
- ❑ Asthma
- ❑ Congestive heart failure
- ❑ Severe diabetic
- ❑ Severe depression
- ❑ Obsessive compulsive disorder

Family Chiropractic
Informed Consent for Chiropractic

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.**

One disturbance to the nervous system is call a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name	Signature	Date

Doctor's Signature

Minors:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Females:

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: _____

Signature	Date

Revised 11/2016