(952) 854-0057 - clinic
(952) 854-0058 - fax
www.innatechiro.net

INNATE & HYACK
• FAMILY CHIROPRACTIC •

2626 East 82nd Street
Suite 103
Bloomington, MN 55425

Listening, Caring, & Getting Results One Patient at a Time

PERSONAL INFORMATION:

How did you hear about us?_____

Name: _____ Height _____Weight _____ Today's Date: _____/_____/_____

Nickname: _____ Birth date: _____ Age: _____ SS#: _____

Home Address: _____
(STREET) (CITY) (STATE) (ZIP)

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Occupation: _____

Spouse's Name: _____Number of Children_____

Emergency Contact (NAME): _____ (PHONE #): _____

Email Address (For Internal Newsletter): _____

PATIENT CLINICAL PROFILE:

Health complaint/symptoms: _____

Previous treatments, medications, surgeries (RELATED TO COMPLAINT): _____

Prior Chiropractic Experience: _____

PAST HEALTH HISTORY:

Previous Illnesses:_____

Surgeries: Date:_____ Type of Surgery:_____

Previous injury or trauma: _____

Are you taking (please list) any medications?_____

Have you had any difficulties with any of the following systems or organs?

___Cardiovascular/Heart/Blood	___Digestive/Bowel	___Immune System
___Nervous System	___Lymph System	___Hepatic/Liver
___Pulmonary/Lung	___Brain/Head	___Skin, Hair, Nails
___Reproductive	___Musculoskeletal	___Urinary Tract/Kidney
___Eyes, Ears, Nose, and Throat		
___Other:_____		

Allergies: _____

What do you enjoy doing most in life?_____

Lifestyle (Hobbies, Level of Exercise, Diet, Tobacco, Alcohol, etc.): _____

Are you wearing: ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports

Is there anything not listed that you feel this office should be aware of? _____

WOMEN: **Birth Control?** ☐Yes ☐No **Pregnant?** ☐Yes ☐No ☐ Maybe **Nursing?** ☐Yes ☐No

EVERYONE: We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider & patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our office. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during treatment. I understand the above information and guarantee this form was completed correctly to the best of my knowledge & understand it is my responsibility to inform this office of any changes in the status of my health.

SIGNATURE_____ **DATE** _____/_____/_____

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General Pain Disability Questionnaire

PATIENT INFO:

Name:_____ Date:_____

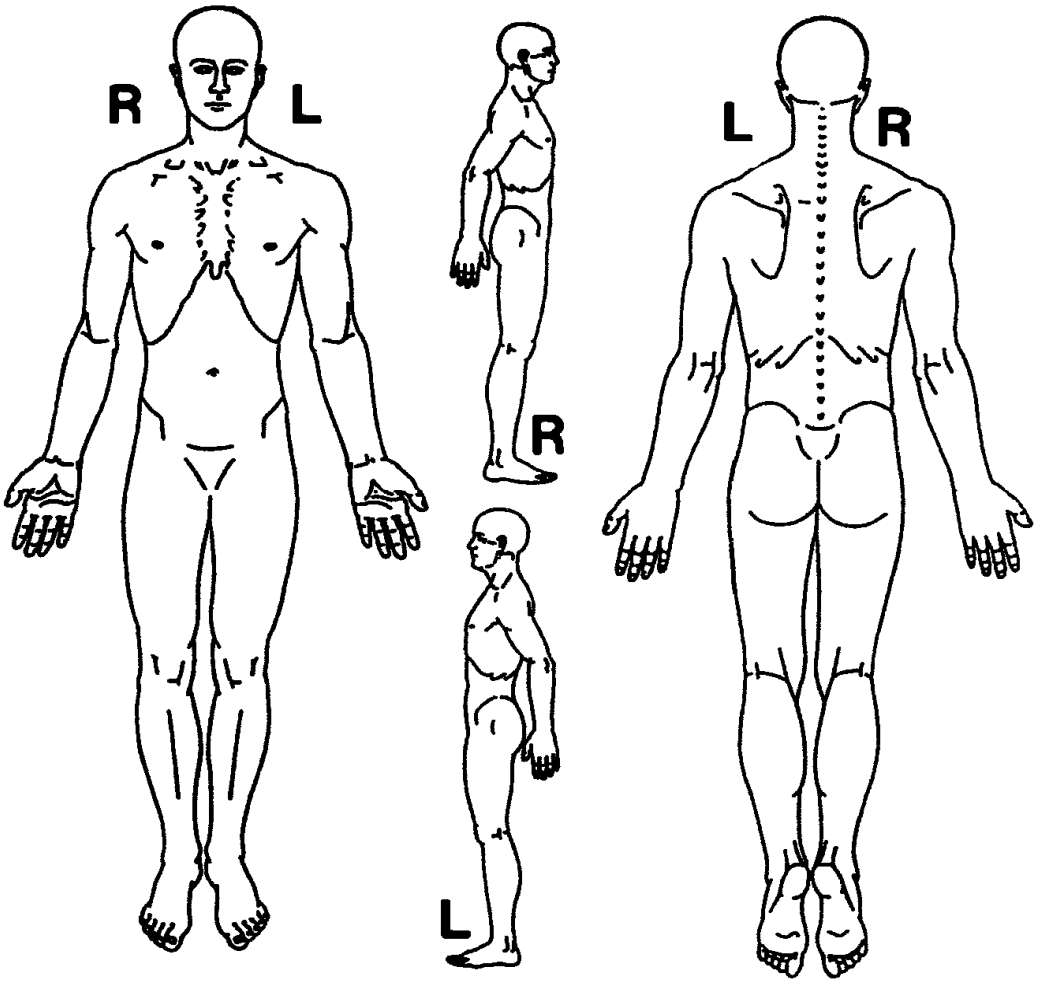
Age:_____ Date of Birth:_____ Occupation:_____

How long have you had this pain?: _____

Is this your first episode of this pain?: ☐ Yes ☐ No Comment: _____

Use the letters below to indicate on the diagram the type and location of your sensations right now.

A = Ache	D = Dull	P = Pins & Needles
B = Burning	N = Numbness	S = Stabbing
C = Constant	O = Other (describe): _____	



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Terms of Acceptance and Consent for Care

This document constitutes informed consent for Chiropractic Care.

When a person seeks chiropractic health care and we accept a person for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that every person who begins care understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

"Vertebral Subluxations" are interference's, by the spinal bones (vertebrae) and/or disc, in the normal transmission of mental impulse traveling over the nerve pathways. The objective of Chiropractic is to analyze the spine, locate and correct these vertebral subluxations.

The Chiropractic method of correction is by specific adjustments of the spine. These adjustments are intended to correct vertebral subluxations over time, thereby allowing the innate (inborn) healing abilities of the body to work at maximum efficiency.

Our initial exam typically includes a study of posture, spinal biomechanics, joint relationships and functional components. A portion of fulfilling this exam is to obtain a spinograph (commonly known as an x-ray) of the vertebral column. This clinic uses Gonstead protocol of 14X36 spinographs, which are ideal for our **chiropractic needs**. So that there is no misunderstanding, these spinographs have limited diagnostic quality from a pathological standpoint and may not be reimbursed by your insurance company. In cases where the insurance company does not reimburse the clinic for the spinographs, the patient is responsible.

We do not offer to diagnose or treat any disease or condition. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend you seek a health care provider that specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements. I therefore accept chiropractic care on this basis.

_____ _____
(**Patient's signature**) (Date)

If patient is a **minor**, print **child's** name _____

I, _____, being the **parent and/or guardian** of the aforementioned child, have read and fully understand the above terms of acceptance and hereby grant permission for this child to receive chiropractic care.

_____ _____
(**Parent/Legal Guardian's Signature**) (Date)

All further procedures shall be agreed upon in writing and signed by both parties.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, [patient's name] acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Innate & Hyack Family Chiropractic LLC, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ _____

Date Signature

_____

Print Name

INSURANCE INFORMATION:

Primary Insurance Co: _____ Group #: _____
Insured's name: _____ Relationship to Insured: _____
Insured's Birth date: _____ Insured's SS#: _____

Secondary Insurance Co: _____ Group #:_____
Insured's name: _____ Relationship to Insured: _____
Insured's Birth date: _____ Insured's SS#: _____

Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above company and assign directly to Dr. Jeffrey Hyack 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE