ABOUT THE PATIENT

Adam Schotzko DC 700 Commerce Drive #120 Woodbury, MN 55125

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Gender ❑ M ❑ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

e-Mail Address _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Emergency Contact _____ ph # _____

Name of Medical Doctor(s)_____ Name of Ins. Co._____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize the release of any medical or other information needed to process my insurance claim.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits to the provider for services shown on the insurance form.
- Person responsible for this account if other than the patient?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing | ❑ Constant ❑ Occasional | ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe | ❑ Worse in the morning ❑ Worse in evening | ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ 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 ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. What makes you feel better? _____

5. What makes you feel worse? _____

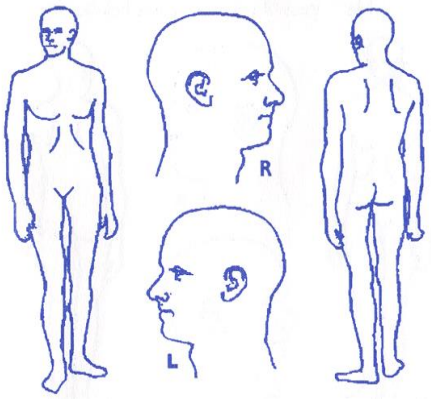
_____

6. What Doctor's and treatment have you seen for this?_____

_____

7. Results: _____

Please mark All areas of concern.



PAST HISTORY

1. List any past auto collisions _____
2. List any past work injuries _____

Was any care received? _____

3. Please list any relevant past hospitalizations and surgeries? _____

_____

4. Please list any relevant past conditions and treatment received_____

_____

GENERAL HEALTH HISTORY

Dr. Adam Schotzko DC, 700 Commerce Drive #120 Woodbury, MN

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Heart Pacemaker
❑	❑	Shortness of Breath	❑	❑	Chest Pains
❑	❑	Allergies / Asthma	❑	❑	Kidney Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Heart Problems	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Liver Disease
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Tension Irritability	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Other _____

1. List any medications you are taking:_____

FAMILY HISTORY

Health problems run in families. Please place a **C** to indicate any Current and **P** for any Past health conditions for each Family Member. Leave blank the spaces that do not apply.

	FATHER AGE___	MOTHER AGE___	SPOUSE AGE___	CHILDERN AGE___	CHILDERN AGE___	CHILDERN AGE___	SIBLINGS AGE___	SIBLINGS AGE___
Condition								
Arthritis								
Asthma								
Back Trouble								
Cancer								
Constipation								
Diabetes								
Disc Problems								
Emotional Problems								
Headaches								
Heart Trouble								
High Blood Pressure								
Insomnia								
Migraines								
Nervousness								
Pinched Nerves								
Scoliosis								
Sinus Trouble								
Stomach Trouble								
Other:								