Personal Information

All information written on this form is considered confidential by Minnesota medical privacy (HIPPA) laws, which protect confidential medical records. Your prior written approval can only access any information listed below.

Name _____ Date _____ Date of Birth _____
Email _____ Cell Phone _____
Home phone _____ Work Phone _____
Address _____
City_____ State _____ Zip Code _____

Describe any current areas of pain or discomfort:

_____
_____
_____

Are you seeing any medical practitioners such as an MD, Osteopath, Chiropractor, Physiatrist, or a Physical Therapist?
Medical Practitioner _____ Office Phone _____
Medical Practitioner _____ Office Phone _____
Medical Practitioner _____ Office Phone _____
Medical Practitioner _____ Office Phone _____

Are you currently taking any medications? If so, what are they and what are they for?
Medication _____ Purpose _____
Medication _____Purpose _____
Medication _____ Purpose _____
Medication _____ Purpose _____

Have you ever had and X-ray, MRI or CAT scan?
Diagnostic Test _____ Date _____ Diagnosis _____
Diagnostic Test _____ Date _____ Diagnosis _____
Diagnostic Test _____ Date _____Diagnosis _____

Have you ever had surgery?
Surgery _____ Date _____
Surgery _____Date _____
Surgery _____ Date _____

Have you ever had cosmetic surgery? (i.e. face lift, breast augmentation, tummy tuck, liposuction, implants, etc.)?

Surgery _____ Date _____
Surgery _____ Date _____
Surgery _____ Date _____

Have you ever broken any bones?

Bone break _____ Date _____
Bone break _____ Date _____
Bone break _____ Date _____

Have you ever been involved in a car accident or had a head injury, such as whiplash, concussion or brain injury?

Type of injury _____ Date _____
Type of injury _____ Date _____
Type of injury _____ Date _____

Do you currently or have you ever had artificial splints, esthetics, dental splints or orthopedic braces?

_____
_____
_____

Do you have a or have you ever been diagnosed with an autoimmune disease or systemic disorder, such as MS, Lupus, Fibromyalgia, Rheumatoid Arthritis, Chronic Fatigue, Epstein Barr, HIV/AIDS, Candida, Cancer, Heart Disease, Diabetes, Lyme's Disease, or any other condition related to immune suppression or systemic inflammation?

Diagnosis _____ Date_____Treatment_____
Diagnosis _____ Date_____ Treatment_____

Do you have a history of food allergies and/or environmental sensitivities?

_____
_____
_____

Have you ever been exposed to chemical irritants such as Agent Orange, lead paint, or occupational chemicals?

Chemical _____ Exposure date _____
Chemical _____ Exposure date _____

What do you do for a living?

_____

How does your job stress your body?

_____

Are you physically active? If so, what do you do for fitness and how often do you do it?

Activity _____ Number of times/wk _____
Activity _____ Number of times/wk _____
Activity _____ Number of times/wk _____
Activity _____ Number of times/wk _____

What are your hobbies?

Activity _____ Number of times/wk _____
Activity _____ Number of times/wk _____
Activity _____ Number of times/wk _____

What else do you do for self-care? (i.e. magnets, stretching, ice, etc)

_____
_____
_____

How would you describe your general state of physical health and energy now?

_____
_____
_____

Are you seeing any other practitioner outside of the traditional medical field, such as an acupuncturist, massage therapist, Rolfer, energy worker, personal trainer, etc?

_____
_____

Have you ever had a negative reaction to any type of therapy? (physical therapy, chiropractic, massage, etc)?

_____
_____

Are you taking any herbs or supplements? If so, what are they and what are they for?

Supplement _____ Purpose _____
Supplement _____ Purpose _____
Supplement _____ Purpose _____

What results do you expect from your time and investment here?

_____
_____

I understand by signing below, that I authorize the release of this information for medical purposes only, and give my specialist permission to contact my medical/care providers in the interest of obtaining medical information regarding my health and medical conditions.

Signed _____ Date _____
Responsible Party (for children under 18) _____ Date _____