

PATIENT CONFIDENTIALITY PERSONAL DATA

No. _____ Date _____
Patient: _____ Date of Birth: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Social Security No.: _____ Home Phone: _____ Mobile: _____
Work Phone: _____ Email: _____
Employer: _____ Address: _____
Name of Spouse: _____ SS No.: _____ No. of Children: _____
Spouse's Employer: _____ Address: _____
How did you learn of this clinic? _____
Nearest relative not living with you? _____ Phone: _____
Who is responsible for payment? Self Spouse Other _____
PATIENT'S INSURANCE SPOUSE'S INSURANCE
Name of Company: _____ Name of Company: _____
Address: _____ Address: _____
ID & Group No.: _____ ID & Group No.: _____
Phone No.: _____ Phone No.: _____
Purpose of this appointment and list your complaints: _____

Date of illness: _____ Time: _____ AM PM Location: _____
How did accident occur? Auto On the job Other, _____
Please describe the circumstances and what makes the condition(s) better or worse: _____

Other Doctor seen for this condition: _____
Have you been treated by a Doctor for any health condition in the last year? Yes No
If yes, please describe: _____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature Physician: _____ Signature Patient: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in any case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature: _____
Parent's or Guardian's Signature: _____

Patient Health Goals:

Name & Date: _____

We all have desires regarding our health, and knowing these goals is very important to Dr. Gansen. The more he can understand your desires for health, the better he can help you achieve optimal health and happiness. Understand that Dr. Gansen has a near 100% success rate helping patients regain strength, vitality, fitness, and well being.

In order to get you better, please tell us your top two health goals:

My primary desire is:

My secondary desire is:

Many patients report with pain, dysfunction, degeneration, and weakness. To better understand how your condition is affecting you, please inform the doctor of your primary fears and limitations that concern your health.

My primary concern or fear is:

My secondary concern or fear is:

HEALTH ANALYSIS

Date _____

Patient _____ Address _____

Marital Status: Single Married Widowed Separated Divorced

Education: High School Some College College Grad Post Grad Studies Full Time Part Time

Age _____ Occupation _____ Recreational Activities _____

Please Circle the Appropriate Answer.

- | | | |
|--|-----|----|
| 1. Do you need glasses to read? | Yes | No |
| 2. Do you need glasses to see things at a distance? | Yes | No |
| 3. Has your eyesight often blacked out completely? | Yes | No |
| 4. Do your eyes continually blink or water? | Yes | No |
| 5. Do you often have bad pains in your eyes? | Yes | No |
| 6. Are your eyes often red or inflamed? | Yes | No |
| 7. Are you hard of hearing? | Yes | No |
| 8. Have you ever had a fluid leaking from your ear? | Yes | No |
| 9. Do you have constant noises in your ears? | Yes | No |
| 10. Do you have to clear your throat constantly? | Yes | No |
| 11. Do you often feel a choking lump in your throat? | Yes | No |
| 12. Are you often troubled with bad spells of sneezing? | Yes | No |
| 13. Is your nose continually stuffed up? | Yes | No |
| 14. Do you suffer from a constantly running nose? | Yes | No |
| 15. Have you at times had bad nose bleeds? | Yes | No |
| 16. Do you often catch severe colds? | Yes | No |
| 17. Do you frequently suffer from heavy chest colds? | Yes | No |
| 18. When you catch a cold, do you always have to go to bed? | Yes | No |
| 19. Do frequent colds keep you miserable all winter? | Yes | No |
| 20. Do you get hay fever? | Yes | No |
| 21. Do you suffer from asthma? | Yes | No |
| 22. Are you troubled by constant coughing? | Yes | No |
| 23. Have you ever coughed up blood? | Yes | No |
| 24. Do you wake up drenched with sweat during the middle of the night? | Yes | No |
| 25. Have you ever had a chronic chest condition? | Yes | No |
| 26. Have you ever had T.B. (tuberculosis)? | Yes | No |
| 27. Did you ever live with anyone who had T.B.? | Yes | No |
| 28. Has a doctor ever said your blood pressure was too high? | Yes | No |
| 29. Has a doctor ever said your blood pressure was too low? | Yes | No |
| 30. Do you have pains in the heart or chest? | Yes | No |
| 31. Are you often bothered by thumping of the heart? | Yes | No |
| 32. Does your heart often race like mad? | Yes | No |
| 33. Do you often have difficulty in breathing? | Yes | No |
| 34. Do you get out of breath before anyone else? | Yes | No |
| 35. Do you sometimes get out of breath just sitting still? | Yes | No |
| 36. Are your ankles often badly swollen? | Yes | No |
| 37. Do cold hands or feet trouble you, even in hot weather? | Yes | No |
| 38. Do you suffer from frequent cramps in your legs? | Yes | No |
| 39. Has a doctor ever said you had heart trouble? | Yes | No |
| 40. Does heart trouble run in your family? | Yes | No |
| 41. Have you lost more than half your teeth? | Yes | No |
| 42. Are you troubled by bleeding gums? | Yes | No |

43. Have you often had sever tooth aches?	Yes	No
44. Is your tongue usually badly coated?	Yes	No
45. Is your appetite always poor?	Yes	No
46. Do you usually eat sweets or other foods between meals?	Yes	No
47. Do you always gulp your food hurriedly?	Yes	No
48. Do you often suffer from an upset stomach?	Yes	No
49. Do you usually feel bloated after eating?	Yes	No
50. Do you usually belch a lot after eating?	Yes	No
51. Are you often sick at your stomach?	Yes	No
52. Do you suffer from sever indigestion?	Yes	No
53. Do severe pains in the stomach often cause you to double up?	Yes	No
54. Do you suffer from constant stomach trouble?	Yes	No
55. Does stomach trouble run in your family?	Yes	No
56. Has a doctor ever said you had stomach ulcers?	Yes	No
57. Do you suffer from frequent loose bowel movements?	Yes	No
58. Have you ever had severe bloody diarrhea?	Yes	No
59. Were you ever troubled with intestinal worms?	Yes	No
60. Do you constantly suffer from bad constipation?	Yes	No
61. Have you ever had piles (rectal hemorrhoids)?	Yes	No
62. Have you ever had jaundice (yellow eyes and skin)?	Yes	No
63. Have you ever had serious liver or gall bladder trouble?	Yes	No
64. Are your joints often painfully swollen?	Yes	No
65. Do your muscles and joints constantly feel stiff?	Yes	No
66. Do you usually have severe pains in the arms or legs?	Yes	No
67. Are you crippled with severe arthritis?	Yes	No
68. Does arthritis run in your family?	Yes	No
69. Do weak or painful feet make your life miserable?	Yes	No
70. Do pains in the back make it hard for you to keep up with your work?	Yes	No
71. Are you troubled with a serious bodily disability or deformity?	Yes	No
72. Do you have sensitive skin?	Yes	No
73. Does it take a long time for a cut to heal?	Yes	No
74. Does your face often get badly flushed?	Yes	No
75. Do you sweat a great deal, even in cold weather?	Yes	No
76. Are you often bothered by severe itching?	Yes	No
77. Does your skin often break out in a rash?	Yes	No
78. Are you often troubled with boils?	Yes	No
79. Do you suffer from frequent severe headaches?	Yes	No
80. Does pressure or pain in the head often make life miserable?	Yes	No
81. Are headaches common in your family?	Yes	No
82. Do you have hot or cold spells?	Yes	No
83. Do you often have spells of severe dizziness?	Yes	No
84. Do you frequently feel faint?	Yes	No
85. Have you fainted more than twice in your life?	Yes	No
86. Do you have constant numbness or tingling in any part of your body?	Yes	No
87. Was any part of your body paralyzed?	Yes	No
88. Were you ever knocked unconscious?	Yes	No
89. Have you at times had a twitching of the head, face or shoulders?	Yes	No
90. Did you ever have a seizure or convulsions (epilepsy)?	Yes	No
91. Has anyone in your family ever had seizures or convulsions (epilepsy)?	Yes	No
92. Do you bite your nails?	Yes	No
93. Are you troubled by stuttering or stammering?	Yes	No
94. Are you a sleep walker?	Yes	No
95. Are you a bed wetter?	Yes	No
96. Were you a bed wetter between the ages of 8 to 14?	Yes	No

Women Only... Are you Pregnant? Yes No

97. W. Have your menstrual periods usually been painful?	Yes	No
98. W. Have you often felt weak or sick with your periods?	Yes	No
99. W. Have you often had to lie down when your periods came on?	Yes	No
100.W. Have you usually been tense or jumpy with your periods?	Yes	No
101.W. Have you ever had severe hot flashes or sweats?	Yes	No
<u>102.W. Have you ever been troubled with a vaginal discharge?.....</u>	Yes	No

Men only...

97. M. Have you ever had anything wrong with your genitals?	Yes	No
98.M. Are your genitals often painful or sore?	Yes	No
99.M. Have you ever had treatment for your genitals?	Yes	No
100.M. Has a doctor ever said you had a hernia (rupture)?	Yes	No
101.M. Have you ever passed blood while urinating?	Yes	No
<u>102.M. Do you have trouble starting your stream when urinating?.....</u>	Yes	No

Everyone...

103. Do you have to get up every night and urinate?	Yes	No
104. During the day, do you usually have to urinate frequently?	Yes	No
105. Do you have severe burning when you urinate?	Yes	No
106. Do you sometimes lose control of your bladder?	Yes	No
<u>107. Has a doctor ever said you had kidney or bladder disease?.....</u>	Yes	No
108. Are you often exhausted or fatigued?	Yes	No
109. Does working tire you out completely?	Yes	No
110. Do you usually get up tired or exhausted in the morning?	Yes	No
111. Does every little effort wear you out?	Yes	No
112. Are you constantly too tired and exhausted even to eat?	Yes	No
113. Do you suffer from severe nervous exhaustion?	Yes	No
<u>114. Does nervous exhaustion run in your family?.....</u>	Yes	No
115. Are you frequently ill?	Yes	No
116. Are you frequently confined to bed by illness?	Yes	No
117. Are you always in poor health?	Yes	No
118. Are you considered a sickly person?	Yes	No
119. Do you come from a sickly family?	Yes	No
120. Do severe pains and aches make it impossible for you to do your work?	Yes	No
121. Do you wear yourself out worrying about work?	Yes	No
122. Are you always ill and unhappy?	Yes	No
<u>123. Are you constantly made miserable by poor health?.....</u>	Yes	No
124. Did you ever have scarlet fever?	Yes	No
125. As a child, did you have rheumatic fever, growing pains, or twitching of the limbs?	Yes	No
126. Did you ever have malaria?	Yes	No
127. Were you ever treated for severe anemia?	Yes	No
128. Were you ever treated for venereal disease?	Yes	No
129. Do you have diabetes?	Yes	No
130. Did a doctor ever say you had a goiter in your neck?	Yes	No
131. Did a doctor ever treat you for a tumor or cancer?	Yes	No
132. Do you suffer from any chronic disease?	Yes	No
133. Are you definitely underweight?	Yes	No
134. Are you definitely overweight?	Yes	No
135. Did a doctor ever say you had varicose veins (swollen veins) in your legs?	Yes	No
136. Did you ever have a serious operation?	Yes	No
137. Did you ever have a serious injury?	Yes	No
<u>138. Do you often have small accidents or injuries?.....</u>	Yes	No
139. Do you usually have difficulty falling asleep or staying asleep?	Yes	No
140. Do you find it impossible to take a regular rest period each day?	Yes	No
141. Do you find it difficult to exercise daily?	Yes	No

142. Do you smoke more than 20 cigarettes a day? Yes No
143. Do you drink more than six cups of coffee or tea a day? Yes No
144. Do you usually take two or more alcoholic drinks a day? Yes No
145. Do you sweat or tremble a lot during examinations or questioning? Yes No
146. Do you get nervous and shaky when approached by a superior? Yes No
147. Does your work fall to pieces when the boss or a superior is watching you? Yes No
148. Does your thinking get completely mixed up when you have to do things quickly? Yes No
149. Must you do things slowly to do them without mistakes? Yes No
150. Do you always get directions and orders wrong? Yes No
151. Are you anxious around unfamiliar people or places? Yes No
152. Are you scared to be alone when there are no friends around you? Yes No
153. Is it difficult for you to make up your mind? Yes No
154. Do you always wish you had someone at your side to advise you? Yes No
155. Are you considered a clumsy person? Yes No
156. Does it bother you to eat anywhere except in your home?..... Yes No
157. Do you feel alone and sad at a party? Yes No
158. Do you usually feel unhappy and depressed? Yes No
159. Do you often cry? Yes No
160. Are you always miserable and blue? Yes No
161. Does life look entirely hopeless? Yes No
162. Do you often wish you were dead and away from it all? Yes No
163. Does worrying continually get you down? Yes No
164. Does worrying run in your family? Yes No
165. Does every little thing get on your nerves and wear you out? Yes No
166. Are you considered a nervous person? Yes No
167. Does nervousness run in your family? Yes No
168. Did you ever have a nervous breakdown? Yes No
169. Did anyone in your family ever have a nervous breakdown? Yes No
170. Were you ever a patient in a mental hospital? Yes No
171. Was anyone in your family ever in a mental hospital?..... Yes No
172. Are you extremely shy or sensitive? Yes No
173. Do you have a shy or sensitive family? Yes No
174. Are your feelings easily hurt? Yes No
175. Does criticism always hurt you? Yes No
176. Are you considered a touchy person? Yes No
177. Do people usually misunderstand you?..... Yes No
178. Is your guard up, even around friends? Yes No
179. Do you always do things on sudden impulse? Yes No
180. Are you easily upset or irritated? Yes No
181. Do you go to pieces if you don't constantly control yourself? Yes No
182. Do little annoyances get on your nerves and get you angry? Yes No
183. Does it make you angry to have anyone tell you what to do? Yes No
184. Do people often annoy and irritate you? Yes No
185. Do you often flare up in anger if you can't have what you want right away?..... Yes No
186. Do you often get in a violent rage?..... Yes No
187. Do you often shake or tremble? Yes No
188. Are you constantly keyed up or jittery? Yes No
189. Do sudden noises make you jump or shake? Yes No
190. Do you tremble or feel weak whenever someone shouts at you? Yes No
191. Do you become scared at sudden movements or noises at night? Yes No
192. Are you awakened out of your sleep by frightening dreams? Yes No
193. Do frightening thoughts keep coming back in your mind? Yes No
194. Do you often become frightened for no apparent reason? Yes No

*Grade Intensity/Severity: (No complaint or pain) 0 1 2 3 4 5 6 7 8 9 10 (Worse possible pain/complaint imaginable)



RIVER VALLEY

FAMILY CHIROPRACTIC

DR. STEVEN GANSEN, D.C.
210 North Meridian Street
Belle Plaine, MN 56011
(952) 873-4275

PATIENT CONSENT

RELEASE OF INFORMATION

By signing this form, you are granting consent to River Valley Family Chiropractic (RVFC) to use and disclose your protected health information for the purposes of treatment, payment, and health operations. Our Notice of Information Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Our Notice of Information Practices before you sign this consent, and encourage you to read it in full.

Our Notice of Information Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at (952) 873-4275. You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent, in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION

I certify that the information given by me in applying for payment under Title XVIII and/or TITLE XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

Print Patient Name _____ Date _____

Patient Signature _____

Other than Patient Name/Relationship _____

Witness _____

**RIVER VALLEY FAMILY CHIROPRACTIC, INC.
INFORMED CONSENT DOCUMENT**

PATIENT NAME: _____ DATE: _____

To the patient: Please read the entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

ANALYSIS/EXAMINATION/TREATMENT

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

Spinal Manipulative Therapy	Palpation	Vital Signs
Range of Motion Testing	Orthopedic Testing	Basic Neurological
Muscle Strength Testing	Postural Analysis Testing	
Ultrasound	Hot/Cold Therapy	EMS
Radiographic Studies	Intersegmental Traction	Other:

THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENT

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

THE PROBABILITY OF THOSE RISKS OCCURING

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during your examination and X-ray. Stroke has been the subject of tremendous disagreement. The instances of stroke are extremely rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS

Other treatment options for your condition may include:

- Self Administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory muscle relaxants and pain killers
- hospitalization
- surgery

THE RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read () or have read to () the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Gansen and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

DATE

DATE

PATIENT'S NAME

DOCTOR'S NAME

SIGNATURE

SIGNATURE

PARENT / GUARDIAN SIGNATURE

INTRODUCTION PATIENT CASE HISTORY

Patient No: _____ Date: _____

Name (Mr. Mrs. Miss Ms.) _____
(Last, First, MI)

Address: _____ City _____ State _____ Zip _____

Home Phone: () _____ Mobile: () _____ Work Phone: () _____

Email Address: _____ Married _____ Single _____ Other _____

Social Security No.: _____ - _____ - _____ Date of Birth: ____/____/____

Occupation: _____ Employer: _____

Name of your Insurance Company: _____

Primary Insurance Holder: _____ Primary Holders Date of Birth: _____

Previous Chiropractic Care? Yes No Doctor's Name: _____

Major Complaint: _____ Began When and How _____

Any Recent Surgeries _____ Any Recent Accident's _____

Medications _____ Allergies RX _____

Physicians Contact _____

Who (or what source) referred you? _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Form 32/C