PRIOR LAKE NATURAL HEALTH CLINIC, P.A.

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Welcome to Our Clinic!

We are happy that you have chosen Prior Lake Natural Health Clinic, P.A. for your health care needs. By choosing this particular type of health care, you have the opportunity to understand the concepts of 'total person health' and obtain information concerning your personal needs for a healthy body. The Doctors of Chiropractic in this clinic have received education and training in the use of Applied Kinesiology, a method of diagnosis that involves the use of muscle testing as a supplemental procedure in diagnosis, treatment, and/or nutritional recommendation.

Payment Policy

Please note that payment is due at the time of each visit. We regret that we are unable to make exceptions to this policy. However, we do accept Visa, MasterCard, and Discover. If you wish to submit to insurance, your receipt is a suitable document to send to your insurance company for reimbursement.

Let us know at 24 hours in advance if you need to cancel your appointment. This time has been reserved for you. If you are unable to use it, please give us the opportunity to offer someone else our care.
<u>If sufficient notice is not provided a $40 late cancel / missed appointment fee will be charged.</u>

What to Expect

Your initial appointment will include an examination and treatment. Additional treatments vary in frequency depending on the severity of the problems(s). Treatments are often scheduled once or twice the first few weeks, then once every other week or two for the next several weeks, and then continue to decrease as your health improves. Some patients will not need to come this frequently. The doctor will often recommend specific supplements for you to take. These would involve additional charges.

We will be happy to answer any questions you may have. Thank you!

Patient / Guardian Signature _____

Confidential Patient Health Record

DATE	I.D. NO.

PERSONAL HISTORY

Name: _____ Address: _____

City: _____ State _____ Zip Code: _____

Home Phone: _____ Birth Date: _____ Age: _____ Sex: ☐ M ☐ F

Cell Phone: _____ E-mail Address: _____

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Business Employer: _____ Type of Work: _____

Business Phone: _____

Name of Spouse _____

Spouse's Employer _____ Business Phone _____

Type of Work _____ Name and Ages of Children _____

Referred To This Office By: _____ _____

Name and Number of Emergency Contact: _____ Relationship: _____

CURRENT HEALTH CONDITION

Unwanted Health Condition _____

Other Doctors Seen For This Condition: ☐ Yes ☐ No ____ Who? _____

Type of Treatment: _____ Results: _____

When Did This Condition Begin? _____ Has This Condition Occurred Before? ☐ Yes ☐ No

Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____

Date of Accident: _____ Time of Accident: _____

Have You Made A Report of Your Accident To Your Employer: ☐ Yes ☐ No

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin ☐ Other _____

Do You Wear A Shoe Lift? ☐ Yes ☐ No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

_____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other _____

Major Accident or Falls: _____

_____

Hospitalization (Other Than Above): _____

_____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

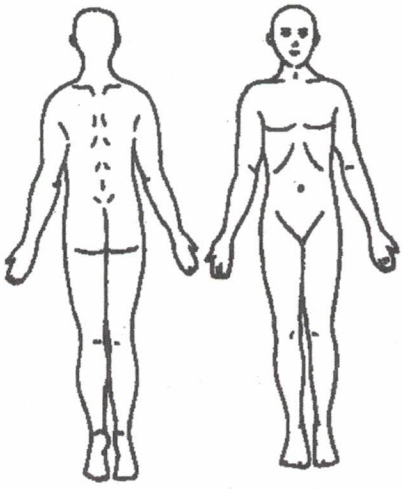
MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FEMALES ONLY:

When was your last period?_____

Are you pregnant?
☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

_____
Doctor's Signature

What is your major complaint?_____

_____

_____

_____

Other Complaints _____

_____

_____

How long have you had this condition? _____
Have you had this or similar conditions in the past? _____
What activities aggravate your condition? _____
Is this condition getting progressively worse? Yes ____ No ____ Constant ____ Comes and goes ____
Is this condition interfering with your: Work ____ Sleep ____ Daily routine ____ Other _____

Do you:	YES	NO	Describe briefly
Now take vitamins or minerals?	_____	_____	_____
Think you may need vitamins or minerals?	_____	_____	_____
Have an allergy to any drug?	_____	_____	_____

Habits:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____

List all conditions for which you have been treated in the past 10 years _____

_____

_____

If your family history shows significant illness, please explain _____

_____

_____

WOMEN'S HEALTH SCREEN

Name _____ Birth Date_____ Today's Date_____

Current health problems/concerns:_____

_____

Current medications, prescription (i.e. hormones) or over-the-counter _____

General Health (check any that apply):

Chronic fatigue___ Irritability___ Shortness of breath ___ Headaches___ Bone pain ___ Memory fails____

Have you experienced unintentional weight loss or gain of 10 pounds or more in the last three months ____

Gynecological History:

Date of last gynecological exam (PAP, mammogram)_____Results_____

Date of last menstrual cycle _____ Length of cycle _____ Interval of time between cycles_____

Any recent changes in normal menstrual flow _____ Age of first period _____

Form of birth control _____ Number of children _____ Number of pregnancies _____

C-section _____ Surgical menopause, date _____ Describe Surgery_____

Endometriosis___ Infertility___ Fibrocystic Breasts___ Fibroids/Ovarian Cysts___Reproductive cancer___

Pelvic Inflammatory Disease___Vaginal Infections ___ Vaginal Candidiasis___ Genital Herpes___ STD__

Family Medical History (check any that apply):

Breast or other cancers ____ Cardiovascular disease____ Osteoporosis ____ Obesity_____ Alcoholism___

Mental Illness/Depression _____ Alzheimer's _____ Diabetes _____ Arthritis _____ Stroke _____

Lifestyle & Diet:

Rate the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) _____

Identify the major causes _____

Do you eat (check any that apply):

Sweets, sodas, ice cream ____ Fried foods ____Whole grains, legumes, cereals ____ Fruits/vegetables____

List your 4 favorite foods _____

Do you (check any that apply):

Diet frequently ____ Skip meals ____ How many meals do you eat per day_____ Dine out regularly_____

Use tobacco/smoke cigarettes ____ How many cigarettes per day _____ Exposed to passive smoke _____

Drink coffee_____ # cups per day_____ Strong ____ Mild _____ Decaffeinated _____Eat Chocolate_____

Drink alcoholic beverages _____ How many ounces per day/per week _____ Preference_____

Exercise daily_____ How many times per week/activity: _____

Do you restrict your intake of or avoid completely (check any that apply):

Dietary fat ____ Dairy products ____ Animal protein ____ Salt ____ Fiber _____ All animal foods_____

Check the symptoms you experience regularly ***one to two weeks before*** *your period:*

Part 1

1.____ Anxiety
2.____ Irritability
3.____ Nervous tension
4.____ Aggressive or hostile toward family/friends
5.____ Engage in self destructive behavior
6.____ Weight gain
7.____ Water retention
8.____ Abdominal bloating
9.____ Tender, swollen and/or painful breasts
10.____ Breast lumps increase in size and tenderness
11.____ Discharge from nipples
12.____ Craving for sweets
13.____ Increased appetite
14.____ Heart palpitations
15.____ Fatigue
16.____ Headaches
17.____ Shaky or clumsy
18.____ Depressed
19.____ Withdrawn
20.____ Confused
21.____ Forgetful
22.____ Insomnia/difficulty sleeping

Continued →

Check the symptoms and/or behaviors that occur ***during your period*** *with a* frequency *or intensity that affects your daily activities:*

Part 2

1.___ Cramping in lower abdomen or pelvic area
2.___ Sharp intermittent pain
3.___ Dull aching pain
4.___ Upset stomach
5.___ Diarrhea
6.___ Nausea or vomiting
7.___ Low back aches
8.___ Headaches
9.___ Difficulty concentrating
10.___ Accident prone
11.___ Unusual fatigue (take naps)
12.___ Decreased productivity
13.___ Weight gain
14.___ Painful and/or swollen breasts
15.___ Irritability
16.___ Mood swings
17.___ Depression
18.___ Painful intercourse

Check off any of the following statements ***that describe*** *your menstrual cycle, energy level or reproductive function:*

Part 3

1.___ Heavy prolonged menstrual bleeding/clotting
2.___ Menstrual bleeding that lasts longer than 5 days
3.___ Absence of periods for 3 months or more
4.___ Vaginal itching, burning, dryness
5.___ Menstruation that occurs too frequently (every 21-24 days)
6.___ Irregular periods (once every three to six months)
7.___ Frequently skip periods
8.___ Menstrual cycle every 36 days or longer
9___ Unusually light or heavy periods
10.___ Unusually light menstrual flow - "spotting"
11.___ Menses last three days and are light
12.___ Bleeding or spotting between period s
13.___ Bleeding between periods is light - "staining"
14.___ Bleeding between periods is heavy and/or clots
15.___ Abnormal vaginal discharge
16.___ Frequent urination

Check any of the following symptoms if they occur ***throughout the month*** *with an intensity or frequency that affects your ability to perform your daily activities or feel good about yourself:*

Part 4

1.___ Decline of vital energy and sense of well-being
2.___ Hot flashes
3.___ Night sweats
4.___ Spontaneous sweating
5.___ Chills
6.___ Depressed
7.___ Irritable
8.___ Anxiety
9.___ Anger
10.___ Mood swings
11.___ Headaches
12.___ Forgetful
13.___ Difficulty concentrating
14.___ Difficulty sleeping
15.___ Urinary problems
16.___ Vaginal problems
17.___ Dry skin
18.___ Bleeding between periods
19.___ Irregular periods
20.___ Stopped menstruating
21.___ Joint and muscle pain
22.___ Change in sexual desire
23.___ Difficulty with orgasm
24.___ Painful intercourse
25.___ Loss of muscle tone
26.___ Vaginal bleeding any time
27.___ Vaginal bleeding after sex
28.___ Vaginal discharge

Additional Comments:

_____

_____

_____

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize _____ Insurance Company/Insurance Administrator to pay by check and for it to be mailed directly to Prior Lake Natural Health Clinic, P.A., the expense benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charge for professional services rendered, and I have agreed to pay, in a current manner, any balance of said professional charges, I agree that this office be given power of attorney and endorse/sign my name on any drafts for payment of my bill.

Patient Signature _____ Date _____ Witness_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the release of any medical information necessary to process my insurance claims(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient Signature _____ Date _____

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize Tammy T. Nyhus, DC,DICCP/Tara L. Roman, DC and whomever they may designate as their assistants to administer chiropractic care as they deem necessary to (Child's name) _____ (Relationship to Child) _____

Parent/Guardian Signature _____ Date _____

LEGAL REPRESENTATION AND PROTECTION OF BALANCE

I, the undersigned patient, am directing my Attorney _____ to pay any outstanding bills out of my settlement, and, in effect, protecting any such balance. I fully understand that I am directly responsible for any medical bills and this agreement is made solely for the doctor's additional protection and consideration of the awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will await payment but will require me to make payment on a current status.

Patient Signature _____ Date _____

PATIENT INFORMATION AND INFORMED CONSENT

I hereby acknowledge that I have read the following statement and agree to the following conditions concerning chiropractic care, nutritional or homeopathic program/consultation, Applied Kinesiology examination/findings, acupuncture, and any supplemental reports.

It is understood that these examinations, programs, and finding are NOT TO TREAT OR DIAGNOSE ANY DISEASE. No guarantees have been made to me that the testing and/or consultation will affect a cure of the symptoms and complaints from which I presently suffer. It is also understood that these procedures are not represented as a practice of medicine.

I agree that any information given from these procedures is for guidance and recommendation only and is not to be regarded as medical advice. At no time will there be any implied and/or stated indications for any patient to discontinue taking any medications as prescribed by his/her physician. At no time will there by any implied and/or stated indication to any patient to discontinue care under the direction of any other physician.

It has been found that complete patient compliance to the natural health care recommendation usually results in greater and more consistent changes towards better health. If you, the patient, wish to decline participation in this program, you may do so at any time. This office reserves the right to dismiss any patient at any time due to poor compliance to the program.

The undersigned agrees that he/she is not an investigator or representative of any state or federal investigatory agency, the American Medical Association, or any media.

Patient Signature _____ Date _____

Continued →

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a 'click' or 'pop', such as the noise when a knuckle is 'cracked', and you may feel movement of the joint. Various ancillary procedures, such as hot or cold pack, electrical stimulation, therapeutic ultrasound or traction may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous stain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as 'rare', about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered 'rare'.

Other treatment options that could be considered may include the following:

- **Over the counter analgesics.** The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- **Medical care,** typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- **Hospitalization** in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- **Surgery** in conjunction with medical care adds risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Patient Signature _____ Date _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Print Patient Name Date

_____

Patient/Guardian Signature