Welcome to *Sugar Creek Chiropractic!*

Dr. Carrie Ross Thompson
112 Second Street West
Chaska, MN 55318

Patient Info

NAME _____

ADDRESS _____ **CITY/STATE/** _____ **ZIP**_____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____

DOB:_____/_____/_____ **Soc. Sec #:**_____-_____-_____

Marital Status: _____S M W_____ **Spouse's Name:** _____

Your Employer: _____ **Occupation:**_____

Who referred you to us? _____

INSURANCE INFORMATION

Insurance Type: _____Health Personal Pay PI/Auto Worker's Comp Medicare_____

Insurance Name: _____

Member #:_____ **Group #:**_____

Insurer's Name (if different From Patient):_____ **Relationship to Patient:**_____

Insurer's DOB:_____ **Insurer's Soc. Sec #:**_____-_____-_____

Insurer's Employer:_____

Person responsible for account:_____

Is there a secondary Insurance? If yes please provide info:

Insurance Name:_____

Member #:_____ **Group #:**_____

Insurer's Name (if different from Patient):_____ **Relationship to Patient:**_____

Insurer's DOB:_____ **Insurer's Soc. Sec #:**_____-_____-_____

WE ACCEPT PAYMENT BY CASH, CHECK, AND CREDIT CARD

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing. Failure to provide secondary insurance information in a timely manner, all services will become patient responsibility.

Signature _____ Date _____

Health History

Reason for consulting this office? _____

_____

Past Chiropractic Care? Yes/No Why? _____

_____ Last Visit _____

CURRENT MEDICAL CARE? YES/NO WHY? _____

Current Drugs/Medication: _____

_____

PLEASE CHECK THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH/WELLBEING.

- ❑ I am only concerned about relief of a particular symptom.
- ❑ I am only concerned about relief of a particular symptom, and preventing its return.
- ❑ I want optimum health and wellbeing on every level available to me.

Have you had

AIDS/HIV	❑ Yes ❑ No	Gonorrhea	❑ Yes ❑ No	Prostate Problems	❑ Yes ❑ No
Alcoholism	❑ Yes ❑ No	Gout	❑ Yes ❑ No	Prosthesis	❑ Yes ❑ No
Allergy Shots	❑ Yes ❑ No	Heart Disease	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Rheumatoid Arthritis	❑ Yes ❑ No
Anorexia	❑ Yes ❑ No	Hernia	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Appendicitis	❑ Yes ❑ No	Herniated Disk	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No	Suicide Attempt	❑ Yes ❑ No
Bleeding Disorder	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
Breast Lump	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Tonsillitis	❑ Yes ❑ No
Bronchitis	❑ Yes ❑ No	Measles	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Bulimia	❑ Yes ❑ No	Migraine	❑ Yes ❑ No	Tumors, Growths	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Typhoid Fever	❑ Yes ❑ No
Cataracts	❑ Yes ❑ No	Miscarriage	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	Mononucleosis	❑ Yes ❑ No	Vaginal Infections	❑ Yes ❑ No
Chicken Pox	❑ Yes ❑ No	Multiple Sclerosis	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Mumps	❑ Yes ❑ No	Whooping Cough	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No		
Epilepsy	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No		
Fracture	❑ Yes ❑ No	Parkinson's disease	❑ Yes ❑ No		
Glaucoma	❑ Yes ❑ No	Pinched Nerve	❑ Yes ❑ No		
Goiter	❑ Yes ❑ No	Pneumonia	❑ Yes ❑ No		

Are you Pregnant?_____ Due Date: _____

Please check any that apply

Injuries/Surgeries	Description	Date
❑ Falls	_____	_____
❑ Head Injuries	_____	_____
❑ Broken Bones	_____	_____
❑ Auto	_____	_____
❑ Surgeries	_____	_____

Habits

❑ Smoking _____Packs/day
❑ Alcohol _____Drinks/week

❑ High stress level Reason_____
❑ Sleep Hours _____
❑ Pillows/Position _____

Chief Complaint:

Name:_____ Date: _____

1. Describe problem or illness: _____

_____

2. Did it start suddenly or gradually? (Circle answer) When did the problem start? ____/____/____
3. What do you think caused the problem? Please describe:

_____

5. What provokes the pain/ discomfort? (Check all that apply)

Sitting_____	Bending_____	Emotional stress_____
Standing_____	Running_____	Certain foods_____
Walking_____	Lying down_____	Other, _____ Please describe below:

_____

6. Have you seen any other doctors for this complaint? Yes / No (Please circle)

Name:_____	Name:_____
Treatment:_____	Treatment:_____
X-rays? Yes / No	X-rays? Yes / No

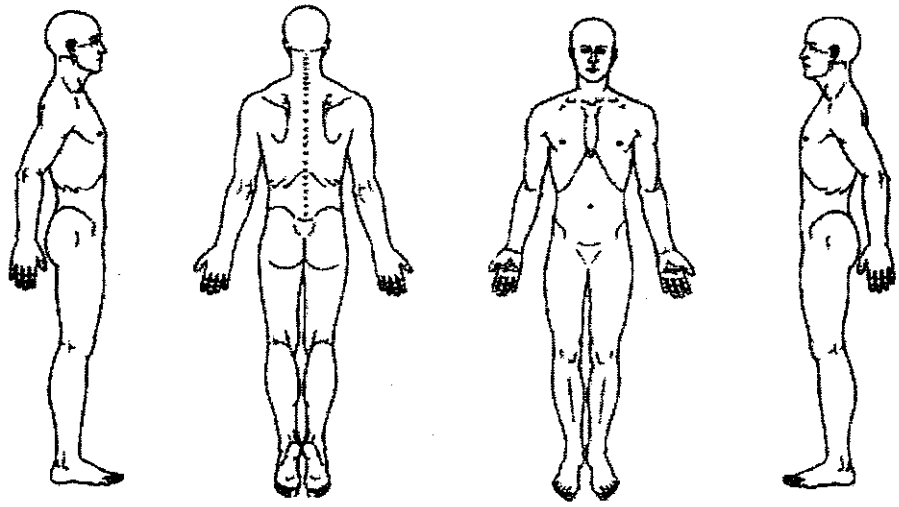
7. Is the pain: Mild____ Moderate_____Considerable_____ Severe._____
8. When does it occur? (Circle one) A.M. P.M. All the time
9. How long does the pain last? _____
10. Is it: (Check all that apply) Sharp_____ Dull_____Hot_____Tight_____Burning_____
    Constant_____ Tingling_____ Numb_____Weak_____Other_____
11. Have you had this problem or similar condition before? _____
12. What other symptoms do you associate with this complaint? Describe:_____

_____

13. On a scale of 1 to 10 how would you rate your pain?

1 2 3 4 5 6 7 8 9 10

14. Using the diagram below, please mark the areas to help explain your complaint.



Carrie M. Ross Thompson, D.C.
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Tel. (952)-448-2722

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112 WEST 2ND STREET STE A, CHASKA, MN 55318
952-448-2722

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, **Sugar Creek Chiropractic** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Sugar Creek Chiropractic's** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Sugar Creek Chiropractic** reserves the right to revise its Notice of Privacy Practices at any time. A review Notice of Privacy Practices may be obtained by forwarding a written request to **Sugar Creek Chiropractic** at 112 West 2nd Street Ste A, Chaska, MN 55318.

With my consent, **Sugar Creek Chiropractic** may call my home or other designated location any items that assist the practice in carrying out TPO, such as birthday cards and patient statements. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

_____ By Initialing here, I am consenting to allow **Sugar Creek Chiropractic** to contact me via telephone, cell phone, text messaging, mail or email correspondence for the purpose of carrying out TPO. IF I do not have access to one or more of these modes of correspondence or prefer to not be contacted via a specific method I will list them here:

_____

By signing this form, I am consenting to **Sugar Creek Chiropractic's** use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. IF I do not sign this consent, **Sugar Creek Chiropractic** may decline to provide treatment to me.

(PATIENT) PRINT NAME: _____

(GUARDIAN) PRINT NAME: _____ RELATIONSHIP: _____

SIGNATURE: _____ DATE: _____

Health Insurance Claim Form Signature Requirement

I AUTHORIZE THE RELASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY CLAIMS. I ALSO REQUEST PAYMENT OF INSURANCE AND/OR GOVERNMENT BENFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO **SUGAR CREEK CHIROPRACTIC** FOR DR. CARRIE ROSS THOMPSON, D.C. FOR SERVICES DESCRIBED ON MY SUBMITTED CLAIMS.

(PATIENT OR GUARDIAN) SIGN: _____ DATE: _____

Revised: 08/2019