600 Twelve Oaks Center Dr #638•Wayzata, MN 55391 (952) 476-0224
1116 6th St•Howard Lake, MN 55349 (320) 543-1104
109 NE 5th St Suite 1•Little Falls, MN 56345 (320) 631-1104
703 Thielen Dr SE•St Michael, MN 55376 (763) 497-1153
621 Parker Ave W • Dassel, MN 55325 (320) 275-1304

Patient's Information/Medical History

Last: ______________________________**First**:_____________________________**MI:**______ **Date of Birth:**___________

SS#:________________________ **Sex:**____ **Marital Status:** □ Single □ Married □ Divorced □ Widowed □ Separated

Address:____**Apt #:**__________

City:___________________________________ **State:**_______ **Zip:**___________

Home phone: ______________________ **Work phone:** _______________________**Mobile:** _________________________

May we contact you via email? □ No □ Yes Email:____

Where do you live? □ Private home □ Apartment □ Assisted living □ Other________________________

With Whom? □ Spouse/Significant Other □ Alone □ Child □ Other________________________

Race/Ethnicity: □ American Indian □ Asian □ African American □ Hispanic/latino □ White

Do you have any religious cultural beliefs that will affect your care? □ No □ Yes_____________________________________

Do you have an Advanced Directive? □ No □ Yes ____

Are you currently working? □ Yes: Occupation:______________________________ □ No □ Retired □ Student □ Disabled

Emergency Contact/Relation:____ **Phone:**___________________________

How did you hear about our clinic? □ Doctor □ Friend/Family □ Phone book □ Internet □ Flyer □ Newspaper
□ Attended seminar □ Other________________________

Referred by:_________________________________ **Last doctor visit date:** __________ **Next doctor visit date:**__________

Clinic name____ **Clinic phone #**__________________________________

Date of injury:_______________ **Type of injury:** □Work related □Auto accident □Other_______________________

Primary insurance:__________________________________**Policy/group/claim#:**______________________________________

Secondary insurance:________________________________**Policy/group #:**____

Employer (if Work Comp):_____________________________________**Supervisors phone:**______________________________

Address:_____________________________________ **City:**_____________________________ **State:**______**Zip:**____________

Check those that Apply:

□ Diabetes
□ High Cholesterol
□ High Blood Pressure
□ Blood Clots
□ Stroke
□ Ulcers/stomach problems
□ Cancer
□ Gynecological/obstetrical problems
□ Pregnancy: Due date? ____________
□ # of past pregnancies: _______
□ Recent illness, hospitalizations or surgeries
□ Cardiac problems
□ Blood disorder
□ Lung problems
□ Circulatory disorder
□ Thyroid problems
□ Osteoporosis
□ Infectious disease
□ Neurological disorder
□ Emotional / psychological disorders
□ Smoking
□currently □quit____yrs. ag
□ Chemical Dependency
□Allergies:__________________

Have you experienced the following in the past year?

□ Chest pain
□ Heart palpitations
□ Cough
□ Hoarseness
□ Shortness of breath
□ Dizziness or blackouts
□ Coordination problems
□ Weakness in arms or legs
□ Loss of balance
□ Difficulty walking
□ Joint pain or swelling
□ Pain at night
□ Difficulty sleeping
□ Loss of appetite
□ Weight loss/gain
□ Nausea/vomiting
□ Difficulty swallowing
□ Bowel problems
□ Urinary problems
□ Fever/chills/sweats
□ Headaches
□ Hearing problems
□ Vision problems
□ Surgery________________________

Please list any other health problems:____

Please list any medications you are currently taking: ____

Reviewed by______________

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Reason for treatment today: ____

____

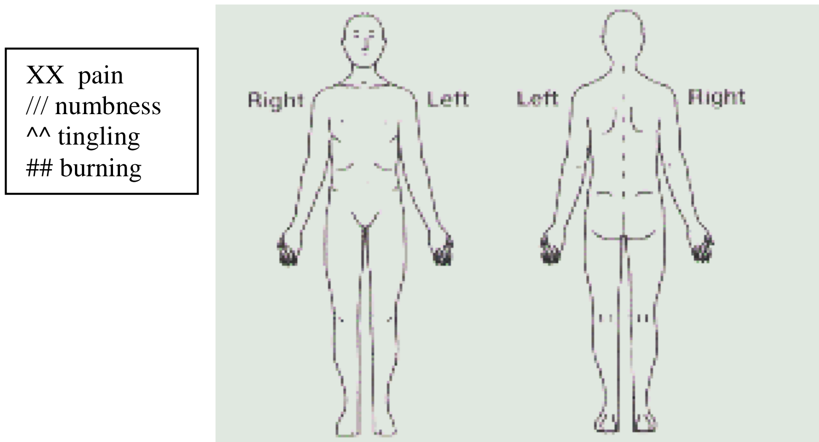
Have you had this problem in the past? □ No □ Yes

If yes, please describe results from previous treatment? ______________________________

Are you currently receiving any other treatments for this condition? □ No □ Yes ______________________

Please list results from any diagnostic tests performed for this condition:______________________

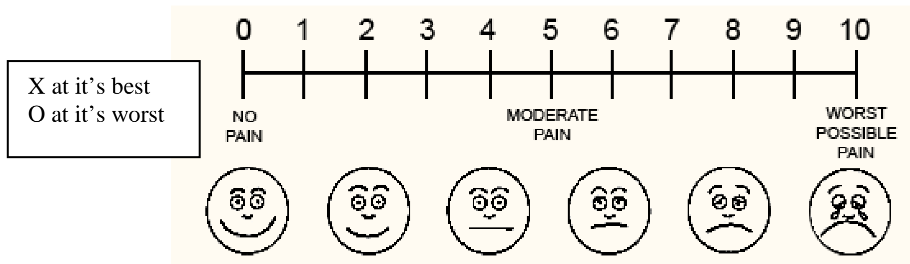
Please describe the location and quality of your symptoms on the chart below.



What makes your symptoms worse?____

What makes your symptoms better?____

Please rate your pain:



Do you exercise? □ No □ Yes

If yes, what type of exercise?____

How many days per week?________

How many minutes per day?________

Please list how this condition is limiting your activity:______________________________

____

What are your goals for therapy?____

____

Reviewed by______________

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