



Jackson Chiropractic Clinic

Jackson Chiropractic Clinic
3508 Rice Street N
St. Paul, MN 55126
(651) 483-4321

Patient Information

Contact Information

Name _____ Nickname _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone(____) _____

Email Address _____

Sex M / F Birth Date ____/____/____ Age _____

Marital Status S / M / D / W Number of Children _____

Work/School Information

Occupation _____ Place of Employment _____

Address _____

Work Status PT / FT Student Status PT / FT School Name _____

Insurance Information

Insurance Company _____

Policy Holder Self / Spouse / Parent

Policy Holder Name _____ Birth Date ____/____/____

Today's Visit

What's bringing you in today? _____

When did your symptoms start? _____

Have you seen other chiropractors recently or in the past? If yes, please list: _____

Referred by: _____



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NEWBORN + INFANT HEALTH HISTORY

Thank you for trusting us with the care of your baby! Please answer the following questions to the best of your ability. Some questions may not apply, depending on the age of your child.

Patient Name _____

What brings you in today? _____

How did this begin? _____ When did it start? _____

Have you seen any other providers regarding this concern? Yes No _____

For each of the descriptions below, place a check in the "past" column if your child has had the description in the past. If he/she has the description currently, place a check in the "present" column.

Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Preferred head position	<input type="checkbox"/>	<input type="checkbox"/>	Frequent hiccups
<input type="checkbox"/>	<input type="checkbox"/>	Frequently arch head and neck backwards	<input type="checkbox"/>	<input type="checkbox"/>	Ear infection(s)
<input type="checkbox"/>	<input type="checkbox"/>	Restrictive movement	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory infection(s)
<input type="checkbox"/>	<input type="checkbox"/>	Has a "strong neck"	<input type="checkbox"/>	<input type="checkbox"/>	High fever
<input type="checkbox"/>	<input type="checkbox"/>	Excessive crying (>3 hrs per day)	<input type="checkbox"/>	<input type="checkbox"/>	Irregular/abnormal bowel movements
<input type="checkbox"/>	<input type="checkbox"/>	Frequent spit up after feedings	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral issues or concerns
<input type="checkbox"/>	<input type="checkbox"/>	Excessive intestinal gas	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Is baby being breast fed? Yes No

If **yes**: Does baby have a preferred breast? Yes, right or left? No

Does baby have a preferred feeding position? Yes No _____

Is baby being formula fed or eating solids? Yes No

If **yes**: What formula or other food source? _____

	Yes	No	If yes, at what age?
Is your child able to sit unsupported?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is your child crawling?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is your child pulling to stand up?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is your child walking?	<input type="checkbox"/>	<input type="checkbox"/>	_____

PREGNANCY + BIRTH HISTORY Pregnancy history unknown

Where was baby born? _____ Was baby born via: Vaginally Cesarean section

What was the term of the pregnancy? _____ weeks

Describe your baby's birth story: _____



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Receipt of Notice for Privacy Practices

I hereby acknowledge receipt of the Notice of Privacy Practices for Jackson Chiropractic Clinic regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized, and disclosed by the Clinic and my respective rights therein. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting (651) 483-4321.

My signature below herein constitutes acknowledgment that I have been furnished a copy of the Notice of Privacy Practices for Jackson Chiropractic Clinic.

Payment Agreement

I authorize the release of any medical information necessary to process insurance billings.

I authorize payment and assignment of insurance benefits to the doctor's office.

I am personally responsible for supplying accurate and current information.

I understand I am financially responsible for all charges and deductibles not covered by my insurance and/or if I supply false or incorrect billing information. I authorize a photocopy of this statement to serve as an original.

Patient Name: _____

Patient Signature: _____ Date: _____

Signature of Parent of Guardian (if a minor): _____



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Informed Consent Document

Please read this 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.

Nature of Chiropractic Care. The primary treatment used by Doctors 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 noise, and 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, but not limited to:

- Spinal manipulative therapy
- Palpation
- Vital signs
- Range of motion testing
- Orthopedic testing
- Basic neurological testing
- Radiographic studies
- Therapeutic ultrasound
- Hot/cold therapy
- Electric muscle stimulation

Risk Inherent with a Chiropractic Care. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. The Doctor will make every reasonable effort during the examination to screen for contraindications of care. These complications include, but are not limited to: muscle strain, burns, fractures, disc injuries, dislocations, cervical myelopathy, and costovertebral stains and separations. Some patients will feel some stiffness and soreness following the first few days of treatment.

Other Available Treatment Options. Other treatment options for your condition may include self-administered over-the-counter analgesics, rest, medical care, prescription drugs, hospitalization, and surgery. If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physicians.

Risk of 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.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my care provider(s) 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.

Patient Name: _____

Patient Signature: _____ Date: _____

Signature of Parent of Guardian (if a minor): _____

Doctor Name: _____

Doctor Signature: _____ Date: _____



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Authorization for Care of a Minor

Patient's Name _____ Date of Birth _____

Parent/Guardian Name(s) _____

Relationship _____ Phone Number _____

I, hereby, authorize Jackson Chiropractic Clinic to render any chiropractic services necessary for the treatment of the minor listed above. These services include but are not limited to: physical examination, x-rays, chiropractic adjustments, therapeutic procedures, traction, electric muscle stimulation, and manual muscle work, within the scope of chiropractic practice.

I, hereby, give consent for the patient listed above to be treated even if I or another parent is unable to attend the chiropractic visit. As a parent/guardian, I am financially responsible for any services rendered during the visit. Any questions or concerns can be directed toward the treating doctor at any time.

Parent/Guardian Signature _____ Date _____

As a Doctor of Chiropractic, we will perform services to the best of our ability, upholding the integrity of our practice. We will treat the patient with respect and only perform services we deem necessary for the treatment of the condition.

Doctor Signature _____

Doctor Name _____ Date _____