New Patient Application

Pietila Chiropractic, LLC, 12358 River Ridge Blvd., Burnsville, MN 55337
(952) 681-7746
John R. Pietila, DC, DACNB, Jennifer L. Engesether, DC, DACNB,
Nicholas C. Moe, DC, Michael P. Hennes, DC

Name:_____ *Date*:_____
(First) *(Middle)* *(Last)*

*Home Address:*_____*City:*_____*St:*____*Zip:*_____

HomePhone:_____*WorkPhone*:_____*CellPhone*:_____

Student Status: ___*FT* ___*PT* *Employment Status:* ___*FT* ___*PT* *Marital Status:* ___ *S*___*M*___*D*

*SSN:*__ __ __-__ __-__ __ __ __ *Date of Birth:* _____/_____/_____ *Sex:* __ *M* __ *F*

Spouse's Name: __*Best Contact Number:*_____

*Emergency Contact:*_____*Phone:*_____

How did you learn about our clinic? _____

*Were you referred by anyone? If so, please name:*_____

Email Address: _____

May we send you clinic updates? (ie: upcoming seminars, newsletter) ___ *yes* ___ *no*

Payment Information

I will be paying today by: □ Cash □ Check □ Credit Card

I authorize Pietila Chiropractic, LLC the release of any medical or other information necessary to process this claim. I request payment of medical benefits from either a government or non-government source to Pietila Chiropractic, LLC. I authorize Pietila Chiropractic, LLC to initiate a complaint to the Insurance Commissioner on my behalf. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including court costs, reasonable attorney fees and all other expenses incurred with collections, if I default on this agreement. In addition, if I issue a check that is returned by the bank for non-sufficient funds, I understand I will be charged $30.00 for each returned check. If I choose to use my non-contract insurance company I will be considered a cash patient by Pietila Chiropractic. Payment for professional services are due at the time of service. After paying in full I will receive a receipt with the appropriate billing and diagnosis codes to submit to my insurance company myself by following the directions on the back of my insurance card. My insurance company will reimburse me directly. I certify the information above is true and correct to the best of my knowledge.

Signature: _____ Date: _____

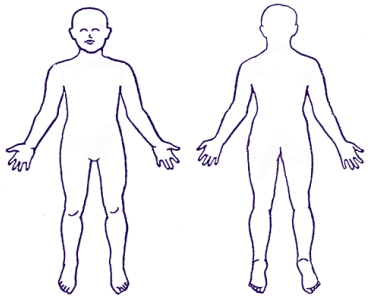
Chief Complaint – Present Condition

Name: **DOB:**

When did your complaints and/or symptoms begin? _____
Describe your current injury or your current problem: _____
_____

Please mark your symptoms on the diagram.

Aching – XXX
Burning - ###
Numbness - ///
Pins/Needles – 000
Stabbing - •••



Rate your pain right now (mark as "N"); worst (mark as "W"); best (mark as "B")

0 1 2 3 4 5 6 7 8 9 10

⇐_____⇒

no pain mild moderate severe very severe worst possible

Please check all present symptoms related to your current condition:

Head & Face

__ base of skull __ side/temple __nausea/vomiting __ ear pain __throbbing __ migraine
__ incapacitating __ front __ ringing in ears __ nose bleeds __ eyelids heavy __ top
__ double vision __ pressure __ head feels heavy __ eye pain __ jaw pain __ flushing
__ light sensitive __ blurry vision __ headache affects vision __ dizziness __ sinus problems

Neck

__ weakness __ spasms __ pain on motion __ limited motion __ pain __ swelling
__ lumps __ throat tight __ radiating pain __ difficulty swallowing __ stiffness

Shoulder, Arm & Hand

Shoulder: __ local pain __ limited movement __ pain on movement __ pain from neck __ radiates down arm
Arm & Hand: __ local pain __ pain on movement __ swelling __ cold hands __ weakness
__ radiates from neck __ numbness/tingling __ cannot raise arm

Mid-back & Low-back

__ weakness __ pain __ spasms __ rib pain __ chest pain __stiffness __ swelling __ pain on motion
__ limited motion __ radiating pain

Hips, Legs, Knees and Feet

__ local pain __ radiating __ from back __ down leg __ swelling __ numbness __ tingling __ spasms
__ cramping __ cold feet __ weakness __ pain on motion __ varicose veins

Nerves

__ burning __ numbness __ tingling __ tremor __ dizziness __ loss of balance __ loss of consciousness
__ coordination __twitching __difficulty with memory __seizures __ generalized weakness

Sleep

__ good __ fair __ poor __ poor due to pain __ deep burning pain
__ difficulty falling asleep __ difficulty staying asleep __ wake often

Fatigue

__ must rest during day __ cannot get enough rest __ intermittent fatigue __ constant fatigue
__ worse with exercise __ mental fatigue __ physical fatigue

Past Medical History

Name: **DOB:**

Please mark any of the following that you have experienced in the ***past 6 months***

Head, Ears, Eyes, Nose and Throat

□ vision problems □ eye pain □ hearing difficulty □ dental problems □ headaches
□ earache/infections □ sore throat □ ringing in ears □ sinus congestion □ nose bleeds
□ bleeding in gums/lips □ loss of smell □ poor night vision

Cardiovascular and Respiratory

□ chest pain/tightness □ low blood pressure □ fainting □ shortness of breath □ cold hands/feet
□ high blood pressure □ varicose veins □ dizziness □ swelling of legs/feet □ coughing blood
□ lung problems □ persistent cough □ light headed □ irregular/fast heartbeat

Gastrointestinal

□ nausea □ vomiting □ heartburn □ gas/bloating □ bloody stools
□ esophageal reflux □ constipation □ hemorrhoids □ ulcers □ diarrhea
□ gallbladder problems □ bowel incontinence □ abdominal pain/cramps

Genitourinary

□ pain with urination □ frequent urination □ kidney stones □ loss of bladder control □ infection
□ wake to urinate □ blood in urine □ sexual dysfunction □ urgency with urination □ STD

Male/Female Systems

□ prostate problems □ irregular periods □ sexual dysfunction □ vaginal pain/infection □ menopause
□ menstrual cramps □ breast pain/lumps __ # of pregnancies __ # of live births __ # of C-Sections

Musculoskeletal

□ joint pain □ muscle pain □ back stiffness □ joint stiffness □ back pain
□ muscle stiffness □ joint swelling □ difficulty with limb movement

Nervous System

□ nervousness/anxiety □seizures/convulsions □ dizziness □ depression □ forgetfulness
□ confusion □ paralysis □ numbness/tingling □ weakness

General

□ weight loss □ weight gain □ night sweats □ excessive thirst □ chills
□ fever □ insomnia □ fatigue □ bruise/bleed easily □ itching
□ spots on fingernails □ fragile/brittle nails □ headaches □ skin rash/sores □ other _____

Past Medical History (Continued)

Name: **DOB:**

Have you ever been hospitalized? □ Yes □ No
If so, where and when? _____
_____

Please list your surgery(ies)

Date	Type of Surgery	Results

Are you taking any medication? □ Yes □ No If yes, please complete table below:

Medication Name	Dosage	How Often Taken	How long have you been taking this medication?

Are there any medications you have had an allergic reaction or unpleasant side affects? _____
_____

Are you currently taking any supplements? □ Yes □ No If yes, please complete table below:

Supplement Name	Dosage	How Often Taken	How long have you been taking this medication?

Have you had an allergic reaction to the following?

□ latex and rubber □ bee or wasp stings □ adhesive tape
□ iodine or x-ray contrast dye □ influenza vaccination □ other: _____

Do you have any food allergies? □ Yes □ No If yes, please list: _____
_____
_____

Personal and Family History

Name: **DOB:**

Have *you* ever suffered from or been diagnosed as having:

Broken or Fractured Bones	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Vascular Disease	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Seizures/Convulsions	☐ Yes	☐ No	Strokes	☐ Yes	☐ No
A Congenital Disease	☐ Yes	☐ No	Ruptures	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
Coughing Blood	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No
Speech Problems	☐ Yes	☐ No	Head Problems	☐ Yes	☐ No
Eye/Vision Problems	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Difficulty Breathing	☐ Yes	☐ No	Insomnia	☐ Yes	☐ No
Loss of Bowel Control	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Ear/Hearing Loss	☐ Yes	☐ No	Nervousness	☐ Yes	☐ No
Loss of Bladder Control	☐ Yes	☐ No	Constipation	☐ Yes	☐ No
Digestion Problems	☐ Yes	☐ No	Gallbladder	☐ Yes	☐ No
Thyroid disorder	☐ Yes	☐ No	Polio	☐ Yes	☐ No
Rheumatic fever	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No
Sexually Transmitted Disease	☐ Yes	☐ No	Circulatory	☐ Yes	☐ No

Please mark the appropriate boxes to identify ALL illness or conditions, which you know have occurred in *you or your blood relatives*. Indicate "none" if you are unsure.

	Self	Mother	Father	Brothers	Sisters	Grandparents	None
Cancer	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Eczema/Psoriasis	☐	☐	☐	☐	☐	☐	☐
Migraine Headaches	☐	☐	☐	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	☐	☐	☐
Stroke/TIA	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐
Abnormal Bleeding	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Alcohol/Drug Abuse	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Other Psychological/ Mental Illness	☐	☐	☐	☐	☐	☐	☐
Suicide (or attempted)	☐	☐	☐	☐	☐	☐	☐
Genetic Disorder	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Colon Polyp	☐	☐	☐	☐	☐	☐	☐
Hepatitis:	☐	☐	☐	☐	☐	☐	☐
Obesity:	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

If any family member is deceased due to any of the conditions listed above, please list who and of what condition:

_____

_____

Social History

Name: **DOB:**

Are you currently married? □ Yes □ No In a relationship/partnership? □ Yes □ No
Have you been: □ Separated □ Divorced □ Widowed In that past year? □ Yes □ No

What is your current employment status?
□ Full time □ Part time □ unemployed □ retired □ disabled
Occupation: _____

Stress Screening:
□ trouble dealing with stress □ stress induced digesting problems □ health feels out of your hands
□ in therapy or counseling □ suicidal thoughts □ use food or alcohol to deal with stress

Do you find any dysfunction or concerns with:
□ relationship with family □ relationship with friends □ intimate relationships
□ career/work/school □ religious/spiritual path □ physical appearance

Substance Review:

Do you use tobacco? □ Yes □ No Pack per day _____# of years _____
Previously used? □ Yes □ No

Do you use Alcohol? □ Yes □ No Servings per day _____ Days per week _____ # of years_____
Previously used? □ Yes □ No

Do you use Caffeine? □ Yes □ No Servings per day _____ Days per week _____ # of years _____

Self-Care/Home Environment Assessment:

In an average week, how many minutes of moderately vigorous physical activity do you get?
□ none □ 1-30 □ 31-60 □ 61-120 □ 121-180 □ 181-240 □ 241-300 □ 300+

Do you have any special dietary needs or food sensitivities ? □ Yes □ No
If yes, please list:_____
_____

How many servings of fruit do you have in a typical day? □1 □2 □3 □4 □5 □6+

Describe your typical breakfast: _____

Describe your typical lunch: _____

Describe your typical dinner: _____

Do you snack? □ Yes □ No
If yes please list your typical snacks:_____

What are you current living arrangements?
□ House □ Apartment □ Assisted Living □ Nursing Home □ Other _____

Do you live: □ alone □ with spouse/family □ with others

History of Care (Current Condition) **Name:** **DOB:**

Primary Medical Physician: _____ Phone: _____
Primary Clinic Name/Location:_____

Do you have medical records that have been created or have you seen another doctor because of your current condition? □ Yes □ No
If so, please list the doctors that have seen you for your current complaint.

1. Name: _____ Phone: _____ City/State: _____

2. Name: _____ Phone: _____ City/State: _____

3. Name: _____ Phone: _____ City/State: _____

Have you had any diagnostic tests performed by the aforementioned doctors or any other Doctors? □ Yes □ No
If so, please check the tests you may have had performed:
□ MRI □ X-Ray(s) □ Lab Work □ Functional Testing □ Psychological Testing
□ Electro-diagnostics □ Other(s) _____

To help the doctor determine your needs, please indicate your specific interests:

□ Chiropractic Adjustments
□ Neurological Evaluation
□ Nutritional Counseling (recommendations)
□ Dietary Counseling (recommendations)
□ Exercise Consultation
□ Life Style Coaching

Upon signature of this document I am certifying that all the information provided is true, correct and complete. If more information about my illness becomes known, I will tell the doctor when possible so that it can be added to my record.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____
(please sign, print your name and relationship to the patient)