

Dr. Todd D. Anderson
Chiropractic Physician
Applied Kinesiologist

PATIENT INFORMATION

MOMENTUM HEALTH
231 MAIN ST NW, SUITE 2
ELK RIVER, MN 55330

PERSONAL INFORMATION

Last Name _____ First _____ Nickname _____ Middle Initial _____
Prefix _____ Generation _____ Sex _____ DOB _____ SSN _____
Marital Status _____ Height _____ Weight _____
Address _____ City _____ State _____ Zip _____
Phone (Home) _____ (Work) _____ (Cell) _____
Email _____ Occupation _____ Employer _____
Who referred you to our office/How did you hear about us? (please be specific) _____
Emergency Contact _____ Relationship _____ Phone _____

I authorize release of all information necessary to process my insurance claims. I assign and request payment directly to my physician. I understand all charges, deductibles, co-payments and/or co-insurance are the responsibility of the patient and verification of benefits does not guarantee payment. I agree to pay for all charges deemed as patient responsibility and any charges for non-covered services as required by law.

As part of your health care, it is necessary to create, maintain and (in certain situations) share medical information concerning your health history and current health care services to carry out treatment, payment and health care options. Our **Notice of Privacy Practices** describes how we may use and disclose your protected health information. You have the right to review our notice before signing this consent. The terms of our notice may change. A current copy of the notice will be available in our facility and you may request one at any time.

By signing this form, you consent to our use and disclosure of your protected health information and acknowledge that you have reviewed our **Notice of Privacy Practices**. You have the right to revoke this consent, in writing, except where we have already used or disclosed your information in reliance on your prior consent. **By signing this form, I also agree that I have received, read, and understood a copy of True Health's Office Policies and Procedures. I am aware that this form will be retained in my medical record.**

Print Patient's Full Legal Name

Date

Patient Signature or Legally Authorized Individual/Guardian

Date

Momentum Health Employee Signature

Date

First Visit Date

PIN _____ (For office use only)

PATIENT INFORMATION

PRIMARY CONCERN

What is the reason for today's visit? _____

Date of first occurrence _____ Date of most recent occurrence _____

Is your condition the result of an accident? (please explain...Car? Work?) _____

Have you had this or similar symptoms in the past? _____

What makes you feel better? _____ Worse? _____

How would you describe the pain? (burning, sharp, stabbing, dull, aching...) _____

How would you rate your pain on a scale of 1-10? (1 is almost no pain, 10 is worst ever) _____

Is the condition getting worse? _____ Is it worse at a certain time of day? _____

Is the condition constant? _____ Does it come & go? (explain) _____

Is this condition interfering with Work/School? _____ Sleep? _____ Activities? _____

Please list your goals for treatment (immediate & future): _____

Are you also concerned with optimizing your overall health and well-being? _____

HEALTH HISTORY

List other current health issues & problems: _____

List other practitioners seen, treatments, self-care activities & results: _____

List any illness you may have had if not previously mentioned: _____

List all surgeries with dates & results: _____

Have you ever been in an accident or seriously injured? (motor vehicle, hard falls, broken bones...) _____

Do you have any dental or TMJ problems? _____

Do you have any allergies? (medications, substances, foods...) _____

List all medications, vitamins, herbs & other supplements you are currently taking: _____

PATIENT INFORMATION

PAIN EVALUATION

Time of day when pain is worst: __Morning __Afternoon __Evening __Wakes Me/Night

Does the pain radiate? _____

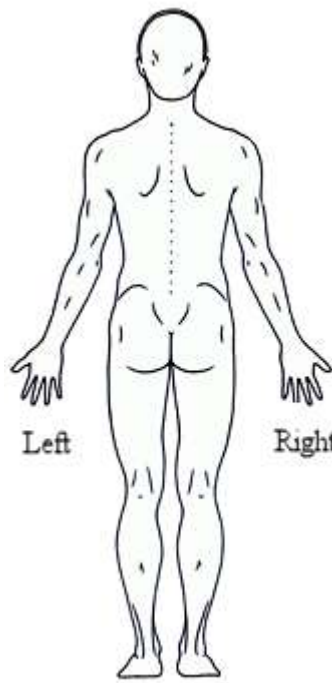
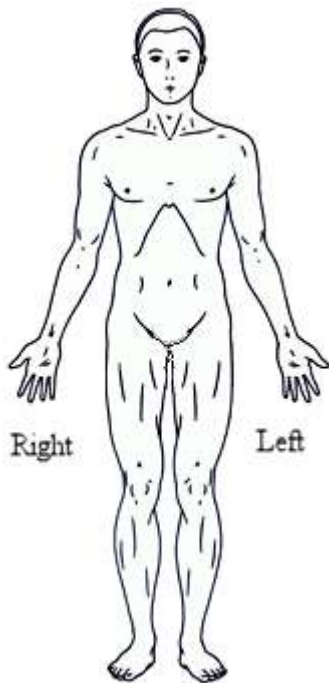
Please circle on the pain scale from 0 to 10 the pain you feel with this condition.

10 being the worst pain you have felt with this condition, 0 being no pain.

Mark areas of pain on figures below.

Type of Pain: (S) Stiffness (B) Burning (N) Numb/Tingling
 (I) Intense/Sharp (A) Achy/Soreness (O) Other: _____

Pain Chart



- Neck Pain**
0 1 2 3 4 5 6 7 8 9 10
- Shoulder, Arm Pain**
0 1 2 3 4 5 6 7 8 9 10
- Mid Back Pain**
0 1 2 3 4 5 6 7 8 9 10
- Low Back Pain**
0 1 2 3 4 5 6 7 8 9 10
- Hip, Leg Pain**
0 1 2 3 4 5 6 7 8 9 10
- Foot, Ankle Pain**
0 1 2 3 4 5 6 7 8 9 10
- Other Pain**

****PLEASE MARK & EXPLAIN ALL PLACES THAT HAVE EVER BEEN INJURED****
 (sprains/strains, broken bones, severe bruises, surgery, scars, cuts, burns, head trauma, etc.)

WHAT HAPPENED?	WHEN DID IT HAPPEN?

PATIENT INFORMATION

FAMILY HISTORY

Please list age(s) and health problems (if any); if deceased, please list age at death and cause of death:

Father _____ Mother _____

Grandparents _____ Children _____

Brothers _____ Sisters _____

LIFESTYLE & HABITS

When was your last physical exam? _____ Blood Tests _____
(please remember to bring copies of any tests and/or reports, ie. Blood, Cholesterol, X-Ray, MRI, etc.)

Describe your use of: Cigarettes/Tobacco _____ Alcohol _____
Other drugs/substances _____

Describe your present exercise habits & physical activities you participate in: _____
(Include frequency per week, duration, & heart rate) _____

*How many hours per night do you sleep on average? _____ *Do you fall right asleep? YES NO

*Do you sleep through the night without waking? YES NO *Do you remember your dreams? YES NO

*Do you have nightmares? YES NO *Do you have night sweats? YES NO *DO you snore? YES NO

*Do you wake up feeling refreshed? YES NO *What is your daily energy level? (1 low - 10 high) _____

What are the major stressors in your life? _____

Are you willing to change your diet if it will improve your symptoms? YES NO MAYBE

Are you willing to do daily exercises to improve your condition? YES NO MAYBE

How much time can you invest? 15 min 30 min 45 min 1 hr +

By signing this form, I give consent to receive treatment from the physician and employees at True Health. I also certify that this information is accurate & complete to the best of my knowledge, and I agree to notify the doctor or his staff of any changes in my condition, symptoms, and/or treatment.

Patient Signature

Date

Momentum Health Employee

Date

PATIENT INFORMATION

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

MUSCLES & JOINTS

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains
- Broken Bones

CARDIO-VASCULAR

- High Blood Pressure
- Heart Attack
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

EAR/NOSE/THROAT

- Earache
- Ear Noises
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

GASTRO-INTESTINAL

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

RESPIRATORY

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

SKIN OR ALLERGIES

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy _____

FOR WOMEN ONLY

- Birth Control _____
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain
- Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and I understand that it is my responsibility to inform this office of any changes. I agree to allow this office to examine me for further evaluation and treatment.

Patient Signature _____ **Date** _____

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OTHER PERTINENT INFORMATION

*Please include any other info you believe would be helpful in your overall evaluation and treatment.