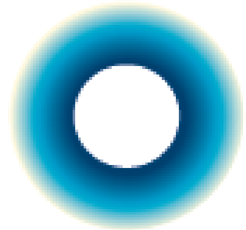

1015 Helmo Ave N. Oakdale, MN 55128 ▪ Phone (651)739-2500 ▪ Email : drben@oschw.com, drheidi@oschw.com

Confidential Patient Application

Please invest a few moments to answer these questions so the Doctor can help you get better faster.

PATIENT INFORMATION:

Name: ______________________ Date: __________

Sex: M or F
Marital Status: S M D W

Date of Birth: __________
Age: __________

Home Phone: ( ) ____ - ______
Cell Phone: ( ) ____ - ______

Email: __________
SSN: ______ - ______ - ______

Address: ______________________
City: ______________ State: ______ Zip: ______

Employer/Occupation: ______________________
Work Phone: ( ) ____ - ______

SPOUSE INFORMATION:

Name: ______________ DOB: __________
Employer: ______________ SSN: ______ - ______ - ______

Who referred you to our office? ______________________

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

Reason for Consulting our office:

Relief of Symptoms ☐ Correction of a Problem ☐ Wellness care ☐

List your health concerns in order of importance:

Health Concern	What have you tried to solve this concern?
1.	
2.	
3.	
4.	

Have you ever been to a Chiropractor? ________ If yes, how long ago? _______________ If yes, what type of care did you receive?

Relief of Symptoms ☐ Correction of a Problem ☐ Wellness care ☐

How do you regularly care for your health? (Circle All which apply)

A. Vitamins/Minerals	B. Holistic Care	C. Exercise
D. Regular Medical	E. Good diet/nutrition	F. Chiropractic
G. Medication	H. Wait for Crisis	I. Other _____________

What have been the results of those choices?

A. Great results	B. Some Results	C. No Change
D. Worse	E. Still Trying	F. Other __________________

This health condition is beginning to affect my….? (Or will affect)

A. Job	B. Marriage	C. Time
D. Kids	E. Self esteem	F. Finances
G. Future abilities	H. Sleep	I. Not Applicable

On a scale of 1 to 10, with 1 being no commitment and 10 being total commitment, how committed to getting well are you?

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

How have family/friends/co-workers been affected by your health condition?

A. No One notices	B. Unable to play with my kids normally
C. I'm told to do something	D. Unable to perform normal at work

What is this costing you? (Happiness, Sleep, Time, Money, Freedom, etc.)

____

____

____

What are you most concerned about regarding this health problem?

____

____

____

Where do you see yourself in 2 years if this problem isn't corrected?

____

____

____

If you didn't have this problem, how would your life be better?

____

____

____

What is your ultimate health goal in working with us?

____

____

____

What is that worth to you**?**

____

____

____

Circle any of the following that are part of your health picture
(past or present):

Allergies	Fibromyalgia	Cerebral Palsy	Digestive Disorders
Cancer	Multiple Sclerosis	ALS	Sinus Trouble
Tuberculosis	Convulsions	Nervousness	Backaches
High Blood Pressure	Epilepsy	Asthma	Numbness
Heart Trouble	Concussion	Dizziness	Arthritis
Diabetes	Hepatitis	Infertility	HIV positive
Headaches	Fatigue	Sleeping problems	Cold Sweats
Mood swings	Loss of smell	Buzz/ring in Ears	Depression
Irritability	Problems urinating	Hot Flashes	Heartburn
Menstrual pain	Menstrual irregularity	Loss of Balance	Fainting

What is the name of your regular Medical Doctor? ____________________________

May We Update your Medical Doctor with our Exam Findings? YES NO

Please Provide Your Doctors Clinic Name/Address Here:

____

____

CURRENT LIST OF SURGERIES, MEDICATIONS, AND HISTORY OF TRAUMA

List all operations and their date:

1. ____
2. ____
3. ____
4. ____

Medications currently taking: (if more than four please provide list)

1. ____
2. ____
3. ____
4. ____

List any significant PHYSICAL traumas from birth to the present:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

List any significant EMOTIONAL traumas since birth:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

How stressful is your life? (1 = No stress | 10 = Extreme stress)

Occupation ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

Personal ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

What do you feel is your primary stress? ______________________________

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your family:

Name	Age	Relation	Conditions

Do you have insurance? YES NO

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, whether or not my insurance company contributes. I hereby authorize the doctors at Oak Springs Creating Wellness Center and whomever they may designate as their assistants to administer care as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or care. I certify that the information in this entire intake form is true and correct. By signing below I also acknowledge receipt of the privacy practices of this office.

______________________________ ______________

Patient's (Parent or Guardian's) Signature Date

If you have insurance please provide your ID Card when you return this form to the receptionist. As a courtesy we will file your insurance for you.

We look forward to serving you!