

TWIN CITIES HEADACHE & NECK

Matthew Collins, DC, DACRB

261 N. Ruth Street, Suite 115 St. Paul, MN 55119 Tel: 651-925-5530 Fax: 651-739-8452

PERSONAL

Name: _____ Date: _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____
Birthdate: _____ Age: _____ Sex: [] M [] F [] Single [] Married [] Divorced Social Security #: _____
Employer: _____ Type of Work: _____ [] Retired [] Student
Address: _____ Business Phone Number: _____
Name of Emergency Contact: _____ Phone: _____

Who is Responsible for your bill? [] Auto Insurance [] Workers Comp [] Self (Medicare/ Any Other Health Insurance)
[] Auto or Work Insurance Company Name: _____
If Auto/Work injury, Have You Reported Your Injury to your Employer or Auto Insurance Company [] Yes [] No
Primary Health Insurance: _____
Policy ID #: _____ Group #: _____
Secondary Health Insurance: _____
Policy ID #: _____ Group #: _____
Do you also have a: [] Health Savings Account [] FLEX Account [] Cafeteria Plan [] Other: _____
Please give all insurance cards to our staff to copy. Our office will provide insurance billing for you. It is your responsibility to pay any deductible, co-insurance, co-pays or as outlined by your insurer.

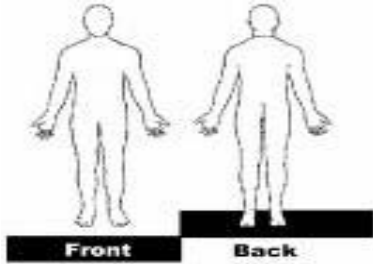
CURRENT HEALTH HISTORY

What is the PRIMARY complaint/ symptom we are seeing you for: _____
(Other complaints/related symptoms we are seeing you for: _____)
On a scale of 0-10 (10 worst, 0 no pain) how severe is your PRIMARY symptom/pain currently: 0 1 2 3 4 5 6 7 8 9 10
What is quality of your pain: [] Sharp [] Dull [] Stabbing [] Throbbing [] Aching [] Burning [] Other: _____
Pain is: [] Constant [] Comes & Goes [] Daily [] Weekly Have you had this problem before? [] Yes [] No
Progression since it began: [] Better [] Worse [] No Change [] Varies Have a fever? [] Y [] N Wake you from sleep? [] Y [] N
What makes you feel worse: [] Sit [] Stand [] Lying Down [] Walk [] Lifting [] Bend [] Stairs [] Other: _____
What makes you feel better: [] Sit [] Stand [] Lying Down [] Ice [] Heat [] Exercise [] Medication [] Other: _____
Condition is: [] Auto Accident [] Work Related [] Home Injury [] Other: _____
Date Condition Began? _____ State/Province/Location of Injury (if auto or work comp): _____
Dates of work missed: _____
Doctors/therapists seen for this condition: _____
Tests/scans performed: [] X-rays [] MRI [] CT scan [] Bone Scan [] Other: _____
Diagnosis recalled: _____
Treatment: _____ Results: _____
Treatment: _____ Results: _____
Current Medication: _____ Reason: _____
Reason: _____
Reason: _____
Current Vitamins/Minerals/Herbs: _____

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Please mark on the diagrams your where your symptoms are located. In the space above, please describe what your goals are and list additional comments.

Personal Medical Doctor: _____ Clinic: _____

Address: _____

May we send report(s) on your condition to keep them updated? Yes No

PAST HEALTH HISTORY

Any childhood illnesses, adult illnesses, accidents, injuries, surgeries, or hospitalizations in your lifetime? None recalled

Yes, list: _____

Have you ever had a fracture (describe): _____

Have you ever in your lifetime treated with: Doctor of Chiropractic Physical Therapy Acupuncture Massage

Amount: Caffeine? _____ day/week, Tea? _____ day/week, Nicotine? _____ day/week, Alcohol? _____ day/week

Do You Exercise Regularly? Yes No (If Yes): Type: _____ Frequency: _____/week

FEMALES ONLY: Are you pregnant? Yes No Not Sure When was your last period? _____

HAVE YOU EVER HAD:

- | | | | |
|------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Recurrent urinary Infections (including Bladder/kidney) | <input type="checkbox"/> Influenza | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Birth Defects |
| <input type="checkbox"/> Pain not improved with rest | <input type="checkbox"/> Groin numbness | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Corticosteroid use | <input type="checkbox"/> Sudden loss of bowel/bladder | <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> IV drug use | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Immunosuppressive Treatment | <input type="checkbox"/> Mumps | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Organ transplant | | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid |
| | | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Seizures |
| | | <input type="checkbox"/> Diabetes I or II | <input type="checkbox"/> HIV |

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS

GENERAL

- Fatigue
- Allergies
- Loss of Sleep
- Fever

MUSCULO-SKELETAL

- Low back pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Difficulty Chewing/Clicking Jaw
- General Stiffness

NERVOUS SYSTEM

- Headaches

NUMBNESS

- Paralysis
- Dizziness
- Nausea
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities

GASTRO-INTESTINAL

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems

GALL BLADDER PROBLEMS

- Weight Trouble
- Abdominal Cramps

GENITO-URINARY

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

C-V-R

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion

VARICOSE VEINS

- Ankle Swelling

EENT

- Stuffed Nose
- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty

MALE/FEMALE

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Other Problems

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FAMILY HEALTH HISTORY Have any blood relatives had the following disorders? If so, list relative.

Table with 8 columns and 6 rows listing various medical conditions such as Anemia, Osteoarthritis, Rheumatoid arthritis, Asthma-Hay Fever, Back Trouble, High Blood Pressure, Bursitis, Migraine, Constipation, Diabetes, Disc Problems, Liver Trouble, Emotional, Emphysema, Epilepsy, Headaches, Heart Trouble, Scoliosis, Kidney Disease, Stomach Trouble, Bleeding Disorders, Migraine, and Cancer.

Please sign & date:

My health information is accurate to the best of my knowledge:

HIPAA Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Signature below is only acknowledgement that you have reviewed this notice of our Privacy Practices. A copy is available upon request: Signature: Date:

CONSENT TO TREAT A MINOR: Name: Guardian: (Printed Name) (Signature & Date)

Informed Consent

Every type of health care is associated with some risk of a potential problem, including chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent. Any procedures intended to help may also do harm. While chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat/ice application, electrotherapy, manual muscle therapy, acupuncture, and rehabilitation) are usually considered remarkable safe and effective, please understand that occasionally there are complications. While the chances of experiencing any of these complications are extremely small, it is the practice of this chiropractic office to fully inform and educate all of our patients about them. These complications include but are not limited to: I understand that there is no guarantee or warranty for a specific cure or result. I understand that I can request further explanation regarding any and all possible risks attendant to my care. I certify that no guarantee or assurance has been made to the results that may be obtained.

- List of complications: Pain, Dire Injury, Burns, Swelling, Soft tissue injury, Bruising/ Discoloration, Bleeding, Stroke (CVA), Bone Fracture, Dizziness/ Weakness, Inflammation, Nausea, Worsening of the condition, Spinal cord damage, Sensory change.

Date: Signature: Printed Name:

Authorization to Release Information & Assignment

Matthew Collins, D.C. (or representative), is authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjustor in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by him (or representative), and I hereby release you of any consequences thereof. I hereby instruct and direct my insurance company to pay by check made out and mailed directly to: Matthew Collins, D.C. and/or if my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows: Twin Cities Headache & Neck, Matthew Collins, D.C.; 261 N. Ruth Street, Suite 115; St. Paul, MN 55119

Date: Signature: Printed Name:

Initials (MEDICARE ONLY): I request payment of medical benefits to the party who accepts assignment A photocopy of this Assignment shall be considered as effective and valid as the original.

Acknowledgement and Understanding

I hereby acknowledge that I am receiving (or about to receive) health care services and/or supplies from Dr. Matthew Collins and that I have been advised that the doctor providing the services and/or supplies is willing to wait for payment for the services and/or supplies, provided that there continues to be a REASONABLE chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. (An insurance company may decide to pay all, some or none of the services and/or supplies provided by Dr. Matthew Collins) I understand that if it is determined that either: a) There is no insurance company obligated to pay for the services and/or supplies, or the insurance involved decides not to pay; b) If a liability claim exists, and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney: I understand that I am then fully responsible for full payment of all services and/or supplies not paid by the insurance company. If a liability claim exists, payment for these services and/or supplies rendered by the doctor will be made on a current basis and my bill will be paid in full as soon as my liability claim is settled or the passage of three months from my last treatment.

Dated Patient/Guardian signature: