RESOLUTION CHIROPRACTIC, P.C.
Dr. Michelle Norton
7300 Metro Boulevard, Suite 145
Edina, MN 55439
Phone: (612) 408-9535
www.ResolutionChiropracticMN.com

Adult
Health Profile

PATIENT INFORMATION _____ File Number_____

Name:_____
Appointment Date: M_____ D_____ 20_____ Birthdate: M_____ D_____ Y_____ SS#_____
Home Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ May we leave a message? ☐ Yes ☐ No
Mobile Phone:_____ May we leave a message? ☐ Yes ☐ No
Work Phone:_____ May we leave a message? ☐ Yes ☐ No
Email:_____
Spouse's Name:_____
Name(s) and Age(s) of Children:_____ _____ _____ _____
Occupation:_____
Do you primarily: ☐ Sit ☐ Stand ☐ Perform Repetitive Tasks
How did you hear about us?_____

HEALTHCARE HISTORY

Have you had previous chiropractic care? ☐ Yes ☐ No
When was the last time you saw a chiropractor?_____
What was the reason for your last chiropractic appointment?_____
Family Doctor:_____
Would you like us to update them of your progress and care? ☐ Yes ☐ No
(We do this as a courtesy to both you and your primary care physician if so desired)

What are your specific concerns for coming in today?_____
_____
_____

How long have you been aware of this? _____Days _____Weeks _____Months _____Years
Where else does the pain go in your body?_____
How often do you experience this? ☐ Daily ☐ Weekly ☐ Monthly ☐ Comes and goes ☐ Constantly
On a scale of 1 to 10 (10 being the worst), how does it feel at its worst? _____
How would you describe the pain/discomfort?
☐ Dull ☐ Achy ☐ Throbbing ☐ Stabbing ☐ Tight/Stiff ☐ Burning ☐ Sharp ☐ Other_____
What makes it feel worse?_____
What makes it feel better?_____
Do you notice any other problems in your body when you get this pain/discomfort?_____

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PERSONAL HEALTH

Have you been involved in any accidents?(car, bicycle, motorcycle, sports, falls at work/home)_____
_____
_____

Have you had any surgeries?
_____
_____

Are you currently taking any medications? Nutritional Supplements? _____
_____
_____

Please check and of the following that you currently have or have had in the past.

☐ Severe or Frequent Headaches	☐ Thyroid Problems	☐ Pain in Arms/ Legs/Hands	☐ Numbness
☐ Heart Surgery/ Pacemaker	☐ Sinus Problems	☐ Osteoporosis/ Osteopenia	☐ Allergies
☐ Lower Back Problems	☐ Hepatitis	☐ Rheumatic Fever	☐ Diabetes
☐ Digestive Problems	☐ Difficulty Breathing	☐ Ulcers/Cholitis	☐ Migraines
☐ Pain Between Shoulders	☐ Kidney Problems	☐ Tuberculosis	☐ Asthma
☐ Congenital Heart Defect	☐ High or Low Blood Pressure	☐ Arthritis	☐ Loss of Sleep
☐ Frequent Neck Pain	☐ Chemotherapy/ Cancer	☐ Shingles	☐ Dizziness

Do you smoke? ☐ Yes ☐ No If yes, how much per day_____
Do you drink alcohol? ☐ Yes ☐ No If yes, how much per week_____
Do you drink coffee, tea, or soda? ☐ Yes ☐ No If yes, how much per day_____
Do you exercise regularly? ☐ Yes ☐ No
Do you wear: ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports ☐ Custom Orthotics
How would you rate your stress level? ☐ None ☐ Low ☐ Moderate ☐ High
What are your goals for beginning care here?_____
_____
_____

Women:
Is there any chance you may be pregnant? ☐ Yes ☐ No
If yes, when is your due date? _____
Are you nursing? ☐ Yes ☐ No
Are you taking birth control? ☐ Yes ☐ No
Do you:
Experience painful periods? ☐ Yes ☐ No
Have irregular cycles? ☐ Yes ☐ No
Have breast implants? ☐ Yes ☐ No

Authorization for Care

I hereby authorize Dr. Michelle Norton to work with my condition through the use of adjustments to my spine and extremities (arms and legs) as she deems necessary and appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. Dr. Norton wil not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become due immediately and payable.

This practice utilizes a "cash" payment system (We accept: Cash, Check, Debt/Credit Cards, HSA and Flex Account Cards). Each adjustment is $65.00 and the Initial Patient Consultation is $110.00. Payment made on the day of service is subject to "Same Day Payment" Benefit Discount = $90 Initial Consultation and $45 Adjustment. Based on an individual's income, we will do our best to accommodate to allow you to receive the best care for you. If you have personal health insurance that reimburses for out-of-network providers, please let us know and we will give you the information to allow you to submit to them directly.

Missed/Canceled appointments with less than 24 hour notice subject to $35 missed appointment fee.

_____ _____

Signature Date

_____

Printed Name

_____ _____

Guardian or Spouse Authorizing Care Signature Date

_____

Printed Name of Guardian or Spouse Authorizing Care

Notice of Privacy Policy

Protecting the Privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and recieve copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indrirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operation such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

Patient Name (Printed) _____ Relationship to Patient_____

Signature_____ Date_____