



ART DISTRICT CHIROPRACTIC
208 13TH AVE NE. MINNEAPOLIS
P: 612-741-2736 F: 612-252-0379

PATIENT INFORMATION

Name: _____
Address: _____
City: _____ Zip Code _____
Home Phone: _____ Work Phone: _____
Cell/Other _____ Preferred #: home work cell
E-mail Address: _____ Birthdate: _____ Age: _____ Gender: M F
Occupation: _____ Employer: _____
How were you referred to Art District Chiropractic?
 Family Member Friend Doctor Other: _____
Please give us the name of the family member, friend, or doctor that referred you _____

In event of an Emergency

Name: _____ Relationship to Patient: _____
Home phone: _____ cell: _____ work: _____

INSURANCE INFORMATION

Auto Accident _____ Work Injury _____ Medicare _____
Medical Assistance _____ Private Insurance _____ Cash _____
Primary Insurance Company _____
ID # _____ Claim # _____ Phone # _____
Address _____
Date of Accident/Injury _____ Attorney _____

I hereby state that the information on this form is true and correct. I authorize Dr. _____ to examine, take x-rays and treat for the care and management of my condition in accordance with the state statutes. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. _____ will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid, be paid directly to Art District Chiropractic, LLC which will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I hereby authorize the release of my health evaluation, examination, prognosis, and treatment records to my employer, attorney, or insurance company. Please notify office staff if you have any questions or concerns regarding this Office Policy Statement. If you are in agreement with this statement please sign and date below.

Patient Signature: _____ Date: _____

Please indicate if you have had or presently have any of the following conditions:

Past	Present		Past	Present		Past	Present	
<input type="radio"/>	<input type="radio"/>	Neck Pain	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Dizziness
<input type="radio"/>	<input type="radio"/>	Upper Back Pain	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Headaches
<input type="radio"/>	<input type="radio"/>	Mid Back Pain	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Stroke
<input type="radio"/>	<input type="radio"/>	Low Back Pain	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Seizures
<input type="radio"/>	<input type="radio"/>	Osteoporosis	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Numbness
<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Muscular Incoordination
<input type="radio"/>	<input type="radio"/>	Joint Stiffness	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Brain Aneurysm
<input type="radio"/>	<input type="radio"/>	Muscle Weakness	<input type="radio"/>	<input type="radio"/>				
<input type="radio"/>	<input type="radio"/>	Jaw Pain	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Hepatitis
<input type="radio"/>	<input type="radio"/>	Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Blood Clots
			<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Easy Bruising
<input type="radio"/>	<input type="radio"/>	Heart Disease/Attack	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Easy Bleeding
<input type="radio"/>	<input type="radio"/>	Pacemaker	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Cancer
<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>				
<input type="radio"/>	<input type="radio"/>	Irregular Heartbeat	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Depression
<input type="radio"/>	<input type="radio"/>	Chest Pains	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	HIV/AIDS
			<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Diabetes
<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Tumor
<input type="radio"/>	<input type="radio"/>	Difficulty Breathing	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Thyroid Disorder
<input type="radio"/>	<input type="radio"/>	Shortness of Breath				<input type="radio"/>	<input type="radio"/>	Abnormal Weight Gain/Loss
			Other Health Conditions			<input type="radio"/>	<input type="radio"/>	Difficulty Sleeping
<input type="radio"/>	<input type="radio"/>	Allergies	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Menstrual Problems
<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	Pregnancy
<input type="radio"/>	<input type="radio"/>	Chronic Sinusitis	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	ADD/ADHD
<input type="radio"/>	<input type="radio"/>	General Fatigue				<input type="radio"/>	<input type="radio"/>	

Indicate if an *immediate* family member has had any of the following:

Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus Stroke Other _____

Surgeries/Hospitalizations/Joint Replacements: _____

Serious Illness or injury/Broken Bones: _____

Allergies: _____

Medications taken within the last two months (include over the counter and vitamins): _____

Habits: Caffeine (use/day) _____ Alcohol (use/week) _____ Drugs (type, use/week) _____

Tobacco: Current Smoker (use/week): _____ Former Smoker, quite date: _____ Never Smoked _____

Are there any other issues concerning your health that you would like the doctor to be aware of? _____

Have you had any other significant traumas? (Auto Accidents, falls, etc): _____

_____ Patient Initial

