chiropractic a r n e wellness center

13911 Ridgedale Dr. STE 440, Minnetonka, MN 55305
(P) 952-697-3100 | (F) 952-541-1756

PATIENT INFORMATION:

DATE: _____ BIRTHDAY: _____

FIRST NAME: _____ MIDDLE NAME: _____ LAST NAME: _____

SEX: ♀ FEMALE ♂ MALE HEIGHT: _____ WEIGHT: _____

MARRIED/CIVIL UNION: _____ SPOUSE NAME: _____ # OF CHILDREN: _____

ADDESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME NUMBER: _____ CELL NUMBER: _____

EMAIL: _____

OCCUPATION: _____ EMPLOYER: _____

ADDESS: _____

CITY: _____ STATE: _____

ZIP: _____ WORK NUMBER: _____

EMERGENCY CONTACT: _____ EMERGENCY RELATION: _____

OCCUPATION: _____ EMERGENCY CONTACT'S PHONE NUMBER: _____

*PARENT/GUARDIAN INFORMATION:

PARENT/GUARDIAN NAME: _____ BIRTHDAY: _____

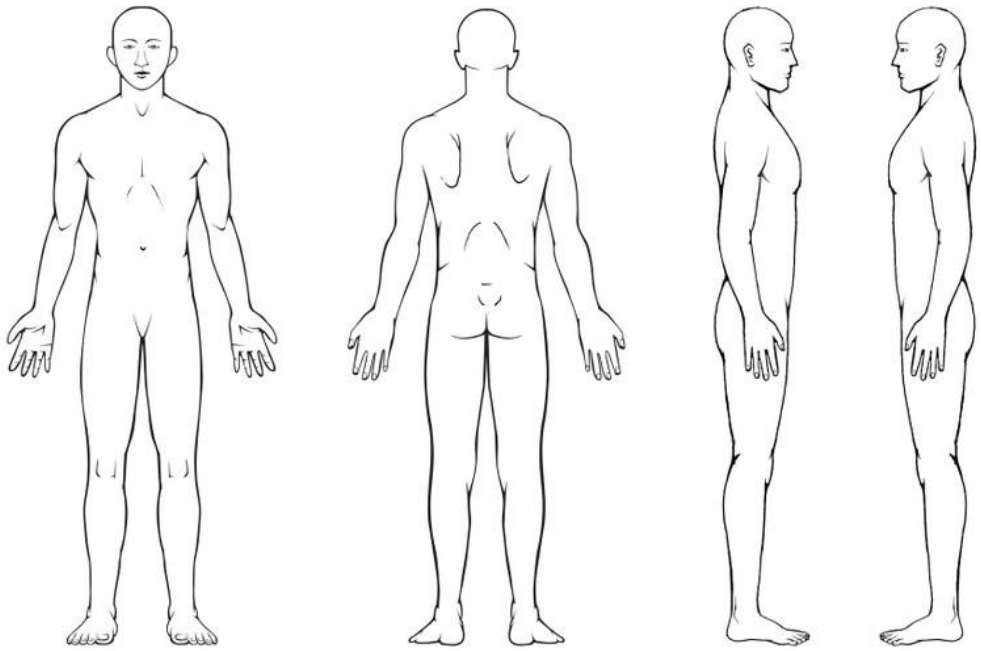
SAME ADDESS? _____

OCCUPATION: _____ EMPLOYER: _____

WORK NUMBER: _____ CELL NUMBER: _____

PATIENT SYMPTOMS:

PLEASE INDICATE WHERE ON THE BODY YOU ARE HAVING SYMPTOMS (SHARP/DULL ACHE/NUMBNESS/SHOOTING/BURNING/TINGLING)



SYMPTOMS: _____

_____

WHEN DID YOUR SYMPTOMS START? _____

HOW DID YOUR SYMPTOMS BEGIN? _____

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS? ○ CONSTANTLY ○ FREQUENTLY ○ OCCASIONALLY ○ INTERMITTENTLY

HOW ARE YOUR SYMPTOMS CHANGING? ○ GETTING BETTER ○ NOT CHANGING ○ GETTING WORSE

INDICATE THE AVERAGE INTENSITY OF YOUR SYMPTOMS (1 BEING NONE – 10 BEING UNBEARABLE): _____

HOW MUCH HAS THE PAIN INTERFERED WITH YOUR NORMAL WORK, INCLUDING BOTH OUTDDOR WORK AND HOUSEWORK?

○ NOT AT ALL ○ A LITTLE BIT ○ MODERATELY ○ QUITE A BIT ○ EXTREMELY

DURING THE PAST 4 WEEKS, HOW MUCH OF THE TIME HAS YOUR CONDITION INTERFERED WITH YOUR SOCIAL ACTIVITIES?

○ ALL OF THE TIME ○ MOST OF THE TIME ○ SOME OF THE TIME ○ A LITTLE BIT OF THE TIME ○ NONE OF THE TIME

IN GENERAL, WOULD YOU SAY YOUR OVERALL HEALTH RIGHT NOW IS…

○ EXCELLENT ○ VERY GOOD ○ GOOD ○ FAIR ○ POOR

PERSONAL HEALTH HISTORY:

PRIMARY CARE PHYSICIAN: _____ CLINIC: _____

ADDESS: _____

CITY: _____ STATE: _____ ZIP: _____

LAST PHYSICAL EXAM: _____ PHYSICIAN PHONE: _____

MEDICATIONS: _____

_____

SUPPLEMENTS: _____

_____

PERSONAL INCIDENT HISTORY:

BROKEN BONES: ◯ YES ◯ NO TREATMENT: ◯ YES ◯ NO EXPLAIN: _____

SPRAINS/STRAINS: ◯ YES ◯ NO TREATMENT: ◯ YES ◯ NO EXPALIN: _____

HOSPITALIZED: ◯ YES ◯ NO EXPLAIN: _____

SURGERY: ◯ YES ◯ NO EXPLAIN: _____

AUTO ACCIDENT: ◯ YES ◯ NO TREATMENT: ◯ YES ◯ NO EXPLAIN: _____

STRUCK UNCONSCIOUS: ◯ YES ◯ NO TREATMENT: ◯ YES ◯ NO EXPALIN: _____

EATING DISORDER: ◯ YES ◯ NO EXPLAIN: _____

STROKE: ◯ YES ◯ NO EXPLAIN: _____

FAMILY HISTORY:

COMPLAINT INFORMATION:

INJURY OCCURRED: ◯ WORK ◯ AUTOMOBILE ◯ THIRD-PARTY ◯ OTHER INJURY DATE: _____

INJURY ORIGIN: _____

DESCRIBE DISCOMFORT: _____

INTERFERE W/ ACTIVITIES: ◯ YES ◯ NO AFFECTED SLEEP: ◯ YES ◯ NO FREQUENCY: _____

MISSED WORK: ◯ YES ◯ NO UNABLE TO WORK FROM: _____ UNABLE TO WORK UNTIL: _____

AFFECTED APPETITE: ◯ YES ◯ NO EXPLAIN: _____

REDUCED WORK: ◯ YES ◯ NO EXPLAIN: _____

DOES IT WORSEN: ◯ YES ◯ NO EXPLAIN: _____

WEATHER AFFECTS IT: ◯ YES ◯ NO EXPLAIN: _____

AGGRAVATES CONDITION: _____

IMPROVES CONDITION: _____

RECEIVED TREATMENT: ◯ YES ◯ NO EXPLAIN: _____

X-RAYS TAKEN: ◯ YES ◯ NO EXPLAIN: _____

SAME CONDITION BEFORE: ◯ YES ◯ NO DATE: _____ PRACTITIONER: _____

GOALS FOR YOUR CARE:

PEOPLE SEE A CIROPRACTOR FOR A VARIETY OF REASONS. SOME GO FOR RELIEF OF PAIN, SOME TO CORRECT THE CAUSE OF PAIN, AND OTHERS FOR CORRECTION OF WHATEVER IS MALFUNCTIONING IN THEIR BODY. YOUR DOCTOR WILL WEIGH YOUR NEEDS AND DESIRES WHEN RECOMMENDING YOUR CARE PROGRAM. PLEASE CHECK THE TYPE OF CARE DESIRED SO THAT WE MAY BE GUIDED BY YOUR WISHES WHENEVER POSSIBLE.

☐ I WANT THE DOCTOR TO SELECT THE TYPE OF CARE APPROPRIATE FOR MY CONDITION.

☐ RELIEF CARE: SYMPTOMATIC RELIEF OF PAIN OR DISCOMFORT.

☐ CORRECTIVE CARE: CORRECTING AND RELIEVING THE CAUSE OF THE PROBLEM AS WELL AS THE SYMPTOM.

☐ COMPREHENSIVE CARE: BRING WHATEVER IS MALFUNCTIONING IN THE BODY TO THE HIGHEST STATE OF HEALTH POSSIBLE WITH CARE.

PATIENT SOCIAL:

ALCOHOL: ○ DAILY ○ WEEKLY ○ OCCASIONALLY ○ NEVER CAFFINE: ○ DAILY ○ WEEKLY ○ OCCASIONALLY ○ NEVER

DIET FOOD PRODUCTS: ○ DAILY ○ WEEKLY ○ OCCASIONALLY ○ NEVER DRUGS: ○ DAILY ○ WEEKLY ○ OCCASIONALLY ○ NEVER

OTC STIMULANTS: ○ DAILY ○ WEEKLY ○ OCCASIONALLY ○ NEVER EXERCISE: ○ DAILY ○ WEEKLY ○ OCCASIONALLY ○ NEVER

HOMEMADE FOOD: ○ DAILY ○ WEEKLY ○ OCCASIONALLY ○ NEVER PROCESSED: ○ DAILY ○ WEEKLY ○ OCCASIONALLY ○ NEVER

SOFT DRINKS: ○ DAILY ○ WEEKLY ○ OCCASIONALLY ○ NEVER TOBACCO: ○ DAILY ○ WEEKLY ○ OCCASIONALLY ○ NEVER

WATER: ○ DAILY ○ WEEKLY ○ OCCASIONALLY ○ NEVER

REFERRAL INFORMATION:

WHO REFERRED YOU TO OUR OFFICE: _____

WHERE DID YOU HEAR ABOUT US: ☐ NEWSPAPER ☐ SIGN ☐ YELLOW PAGES ☐ MAILING ☐ COMMUNITY EVENT ☐ OTHER _____

ADVERTISEMENT: ○ YES ○ NO ADVERTISEMENT: _____

REFERRED DIRECTORY: ○ YES ○ NO REFERRED DIRECTORY: _____

CHIROPRACTIC EXPERIENCE:

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE: ○ YES ○ NO IF YES, WHY? _____

CONDITION(S) TREATED: _____

DOCTOR'S NAME: _____ CLINIC: _____

ADDESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ APPROXIMATE DATE OF VISIT: _____

FOR WOMEN ONLY:

ARE YOU PREGNANT? ○ YES ○ NO ARE YOU TAING BIRTH CONTROL? ○ YES ○ NO DO YOU HAVE IRREGULAR CYCLES? ○ YES ○ NO

ARE YOU NURSING? ○ YES ○ NO EXPERIENCE PAINFUL PERIODS? ○ YES ○ NO DO YOU HAVE BREAST IMPLANTS? ○ YES ○ NO

HEALTH CHECKLIST:

- ☐ ALLERGIES
- ☐ ARTERIOSCLEROSIS
- ☐ BACK PAIN
- ☐ BRUISE EASILY
- ☐ COLD EXTREMITIES
- ☐ DEPRESSION
- ☐ DIZZINESS
- ☐ FATIGUE
- ☐ HEMORRHOIDS
- ☐ INSOMNIA
- ☐ KIDNEY INFECTION
- ☐ LOSS OF BALANCE
- ☐ NOSEBLEEDS
- ☐ PROSTATE TROUBLE
- ☐ SINUS INFECTION
- ☐ ALCOHOLISM
- ☐ ARTHRITIS
- ☐ BREAST LUMP
- ☐ CANCER
- ☐ CONSTIPATION
- ☐ DIABETES
- ☐ EXCESSIVE MENSTRUATION
- ☐ FREQUENT URINATION
- ☐ HIGH BLOOD PRESSURE
- ☐ IRREGULAR HEARTBEAT
- ☐ KIDNEY STONES
- ☐ LOSS OF SMELL
- ☐ POLIO
- ☐ SCIATICA
- ☐ LOSS OF MEMORY
- ☐ ANEMIA
- ☐ ASTHMA
- ☐ BRONCHITIS
- ☐ CHEST PAIN
- ☐ CRAMPS
- ☐ DIGESTION PROBLEMS
- ☐ EYE PAIN OR DIFFICULTIES
- ☐ HEADACHE
- ☐ HOT FLASHES
- ☐ IRREGULAR MENSTRUAL
- ☐ LOSS OF MEMORY
- ☐ LOSS OF TASTE
- ☐ POOR POSTURE
- ☐ SHORTNESS OF BREATH
- ☐ LOSS OF BALANCE

SYMPTOM REVIEW:

CONSTITUTIONAL: YES | NO
- Weight Loss ☐ ☐
- Fatigue ☐ ☐
- Fever ☐ ☐

EYES:
- Glasses/Contacts ☐ ☐
- Eye Pain ☐ ☐
- Double Vision ☐ ☐
- Cataracts ☐ ☐

EAR/NOSE/THROAT:
- Difficulty Hearing ☐ ☐
- Ringing in Ears ☐ ☐
- Vertigo ☐ ☐
- Sinus Trouble ☐ ☐
- Nasal Stuffiness ☐ ☐
- Frequent Sore Throat ☐ ☐

ENDOCRINE:
- Loss of Hair ☐ ☐
- Heat/Cold Intolerance ☐ ☐

GASTROINTESTINAL:
- Heartburn/Reflux ☐ ☐
- Nausea/Vomiting ☐ ☐
- Constipation ☐ ☐
- Change in BMs ☐ ☐
- Diarrhea ☐ ☐
- Jaundice ☐ ☐
- Abdominal Pain ☐ ☐
- Black or Bloody BM ☐ ☐

PSYCHIATRIC: YES | NO
- Anxiety/Depression ☐ ☐
- Mood Swings ☐ ☐
- Difficult Sleeping ☐ ☐

MUSCULOSKELETAL:
- Joint Pain/Swelling ☐ ☐
- Stiffness ☐ ☐
- Muscle Pain ☐ ☐
- Back Pain ☐ ☐

NEUROLOGOICAL:
- Loss of Strength ☐ ☐
- Numbness ☐ ☐
- Headaches ☐ ☐
- Tremors ☐ ☐
- Memory Loss ☐ ☐

SKIN:
- Rash/Sores ☐ ☐
- Lesions ☐ ☐
- Itching/Burning ☐ ☐

CARDIOVASCULAR:
- Murmur ☐ ☐
- Chest Pain ☐ ☐
- Palpitations ☐ ☐
- Dizziness ☐ ☐
- Fainting Spells ☐ ☐
- Shortness of Breath ☐ ☐
- Difficulty Lying Flat ☐ ☐
- Swelling Ankles ☐ ☐

HEMATOLOGY/LYMPH: YES | NO
- Easy Bruising ☐ ☐
- Gums Bleed Easily ☐ ☐
- Enlarged Glands ☐ ☐

RESPITORY:
- Cough ☐ ☐
- Coughing Blood ☐ ☐
- Wheezing ☐ ☐
- Chills ☐ ☐

GENITOURINARY:
- Burning/Frequency ☐ ☐
- Nighttime ☐ ☐
- Blood in Urine ☐ ☐
- Erectile Disfunction ☐ ☐
- Abnormal Discharge ☐ ☐
- Bladder Leakage ☐ ☐

ALLERGIC/IMMUNOLOGIC:
- Hives/Eczema ☐ ☐
- Hay Fever ☐ ☐

FEMALES ONLY:
- Last Mammogram Date: _____
- Normal _____Abnormal _____
- Last PAP Date: _____
- Normal _____Abnormal _____
- Age Onset Periods _____
- Age Onset Menopause _____
- Periods Regular? Yes _____ No _____
- Number of Pregnancies _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund-raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

SIGNATURE OF PATIENT: _____ DATE: _____

PRINTED NAME: _____

MagnaCharger: Pulsed Magnetic Cellular Exerciser

Consent for Demonstration, Session, or Purchase

DISCLAIMER:

The MagnaCharger produces magnetic energy, which passes freely through tissue for the purpose of cellular exercise to promote and support a sense of wellbeing. The MagnaCharger is not a medical device. The MagnaCharge has not been evaluated by the FDA. It is not intended for the diagnosis, treatment, or cure of any medical condition. If you are experiencing the symptoms of a medical condition, you should seek the advice of a medical professional. If you are unsure whether a demonstration or exercise program of pulsed magnetic cellular exercise is right for you, consult with your licensed health care provider(s). as with any exercise program. You may experience natural reactions that include, but are not limited to, nausea, headache, fatigue or muscle aches.

PRECAUTIONS & RECOMMENDATIONS:

- Additional hydration is recommended before and after a session with MagnaCharger.
- Do not use the MagnaCharger if you have an implanted electronic device including:
    - Pacemaker
    - Defibrillator
    - Cochlear Hearing Device
    - Etc.
- Remove all the following from your person:
    - Electronic or Battery-Operated Devices
    - Keys
    - Wallets
    - Jewelry
    - Hearing Aids
- Do not use the MagnaCharger if you are pregnant.
- Do not use during active bleeding, hemorrhaging, or during heavy menstruation.

INFORMED CONSENT:

I hereby request a Pulsed Magnetic Cellular Exercise session. I understand that the MagnaCharger creates a fully adjustable pulsed magnetic field. I understand that the information shared by the demonstrator are his/her personal opinions and are intended for educational purposes only.

Beyond what is stated above, I understand that other risks associated with a pulsed magnetic exercise session are unforeseeable and that the demonstrator, the manufacturer, the marketer, employees, agents, and affiliates cannot accept and liability for the loss or damages incurred as the result of the MagnaCharger session. I reserve the right to use the knowledge I have gained in the care of my own body in any legal matter I may choose. I have read this form and voluntarily agree to the MagnaCharger session on my person assuming all liability for any and all results or consequences.

SIGNATURE OF PATIENT: _____ DATE: _____

PRINTED NAME: _____

HOW WERE YOU INTRODUCED TO OUR TECHNOLOGY?

_____

chiropractic arne wellness center

13911 Ridgedale Dr. STE 440, Minnetonka, MN 55305
(P) 952-697-3100 | (F) 952-541-1756

I certify that I'm the patient or legal guardian listed above. I have read and I understand the included information. I certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to my auto and workers comp insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. ***I understand and agree that all services rendered to me will be charged to me, and I'm responsible for payment at the time of service.*** I understand and agree that, should this be an accident case (auto accident or worker's compensation) and is not fully paid by my insurance, I will be responsible for the remaining balance. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

PRIVACY POLICY: I acknowledge that I have received ARNE WELLNESS CENTER'S privacy policy.

RECORDS RELEASE: I hereby authorize the release of any information, including medical and billing information by ARNE WELLNESS CENTER to my referring doctor/primary care physician, insurance company, the responsible party named above, and immediate family (with separate signed records release) on behalf of myself and/or dependents.

FINANCIAL STATEMENT: I understand that ARNE WELLNESS CENTER is an out of network clinic and that I am responsible for payments of goods and services. I understand that should I chose to submit services to my insurance, I am responsible for submitting my own out of network paperwork. I WILL BE CHARGED FOR CANCELLED, MISSED OR BROKEN APPOINTMENTS WITHOUT 24 HOURS ADVANCE NOTICE. *Exceptions apply.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

TREATMENT OF MINOR CHILD: I hereby authorize Dr. Stephen Arne to provide evaluation, management, and/or chiropractic treatment for my child: _____. I also authorize whomever Dr. Arne may designate as assistants to administer therapy.

SIGNATURE: _____ DATE: _____