RENEWED HOPE CHIROPRACTIC & WELLNESS
"Get Healthy, Stay Healthy and Live the Best Life Possible"
Drs. Garret and Sheila Swenson D.C.

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1726 S. Washington St. Ste. 79
Grand Forks, ND 58201

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date:**
Address: Street City State Zip	
Home phone:	**Work phone:**
Cell phone:	**Email address:**
Best time/place to contact you:	
Date of birth:	**Age:**
No. of children:	**Pregnant? Yes ☐ No ☐**
Height:	**Weight:**
Marital status: M S W D	**Spouse/guardian name:**
Occupation:	
Employer:	
Spouse's Occupation/Employer:	
Name of person responsible for account:	
Do you have insurance that covers Chiropractic care? **Yes ☐ No ☐**	**Do you have Medicare coverage?** **Yes ☐ No ☐**
Name of Insurance Company:	
Insurance Policy number:	**Insurance Company phone number:**
Insurance Company address:	

Who may we thank for referring you?

____

Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the **"General Health History"**.*

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?
____
____

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

What have you done for this condition? Was it of benefit?
____
____

I do (do not) have a family history of this or similar symptoms (Please explain):
____
____

Which activities aggravate your condition?
____
____

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	☐
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	☐
Medical Doctor	☐
Dentist	☐
Other (please describe)	☐

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Is this condition interfering with any of the following:

Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐ (please explain):

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Have you ever had x-rays taken?

Area of body:	When?	Where?

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes No Maybe
If dietary changes are indicated would you be willing to make changes in your diet?	Yes No Maybe
Would you take whole food supplements if indicated?	Yes No Maybe
If specific exercises or stretching would help would you consider adding them to your program?	Yes No Maybe
If reducing stress would you help you would you like to know ways to reduce stress?	Yes No Maybe

Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily **W** - Consume weekly **M -** Consume this monthly **X -** Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. ____
   b. ____
   c. ____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. ____
   b. ____
   c. ____

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. ____
   b. ____
   c. ____

On a scale of 1-10 please grade your present levels of stress 1 being little to no stress 10 being extreme stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you grade your emotional/mental health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

Past Health History

Often seemingly unrelated symptoms can manifest as other health concerns:
(Please circle if you have had any of the following)

Headaches	Irritability	Stroke	Pneumonia
Heartburn	Depression	Cancer	Difficulty Breathing
Upper Back pain	Loss of Balance	Multiple Sclerosis	Asthma
Neck pain	Loss of Concentration	Thyroid Problems	Urinary Problems
Lower Back pain	Loss of Memory	Heart Attack	Constipation
Stiffness	Ear buzzing	Heart Disease	Diarrhea
Reduced Mobility	Poor coordination	Measles	Weight Loss
Numbness in leg(s)	Vision changes	Ulcers	Weight Gain
Numbness in feet	Loss of smell	Arthritis	Dental Problems
Numbness in hands	Sinus Congestion	High Blood Pressure	Fevers
Weakness	Loss of taste	Menstrual Cramps	Chest Pressure
Muscle Cramps	Light sensitivity	Gall Bladder Problem	Breast Pain
Gas	Diabetes	Migraines	Frequent Colds
Sleeping Problems	Gout	Whooping Cough	Sore Throat
Dizziness	Irregular Periods	Face flushed	Allergies
Fainting	Miscarriage	Bronchitis	Ear Infection/Pain

Other (please explain)
____

____

Is there anything else which may help to better understand you which has not been discussed?
____
____
____
____

Why are you here at this point in time?
____
____
____
____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary.
I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: ____ Date: _______________

Signature: ____

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INFORMED CONSENT

I understand and am informed that, as in all health care, in the practice of chiropractic there is a small inherent risk of injury which includes but is not limited to, muscle strains, sprains, fractures, dislocation, intervertebral disc injury, and cardiovascular accident. I understand that Dr Garret and Dr. Sheila will not be able to anticipate all potential complications, but will rely on clinical expertise and judgment to determine the correct course of treatment, which will be in my best interests considering all known facts. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and herby consent to voluntarily participate in orthopedic, neurological and physical performance testing as well as manipulative, and exercise/rehabilitation therapies as deemed appropriate by Dr. Garret and/or Dr. Sheila. If at any time, I have further questions or decide not to continue to consent in treatment, I understand I have the right and it is my duty to notify my doctor.

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Print Patient / Guardian Name Signature Date

NOTICE OF PRIVACY POLICY

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for suture care or treatment. This information is kept private except uses involved in your healthcare.
I understand that this information serves as:
A basis for planning my care and treatment
A means of communication among the many healthcare professionals who contribute to my care.
A source of information for applying my diagnosis and prior health information to my bill.
A means by which a third party payer can verify that services billed were actually provided
A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.
I understand that:
I have the right to object to the use of my health information for directory purposes
I have access to a copy of the “Notice of patient Privacy Rights” and they are available in the office.
I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to the restrictions requested.
I have the right to revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.
I have the right to request a copy of my record. I understand this requires 48 hours notice.
I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by recipient and that this information will no longer be subject to protection as protected health information.

I authorize Renewed Hope Chiropractic, PLLC to speak with the following people regarding my healthcare:

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With my consent, Renewed Hope Chiropractic, PLLC, may call my home or other designated location, and leave a voice message in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and information pertaining to my clinical care.

X____ **Date:** ____________________________

Signature of patient or legal representative