**NEW PATIENT QUESTIONNAIRE**

**Welcome to**

# COMPLETE CHIROPRACTIC, PC

**Dr. Grant L. Modory, D.C.**
**303 Hester Street West**
**Dundas, MN 55019**
**507-645-0333**

## Outline of Procedure for New Patients

1. **STEP ONE**: All new patients are requested to fill out a personal health/history questionnaire.
2. **STEP TWO**: Your first consultation with a doctor to discuss your health problems.
3. **STEP THREE**: Diagnostic chiropractic, orthopedic and neurological examination procedures to determine if chiropractic care is appropriate for your condition.
4. **STEP FOUR**: The doctor will advise you as to the need of additional procedures such as laboratory and x-ray tests, if necessary.
5. **STEP FIVE**: If your case requires immediate attention, emergency first aid will be administered.
6. **STEP SIX**: You will be advised as to a time you can return for your "Report of Findings" when your doctor will inform you as to your examination results and whether or not your case has been accepted. You will also be advised concerning financial arrangements and insurance coverage as appropriate.
7. **STEP SEVEN**: After you return and receive your report of findings your recommended treatment program will be explained to you.
8. **STEP EIGHT**: Treatments will begin and continue as scheduled until your condition has been fully corrected, or until the maximum possible improvement has been obtained.

## PERSONAL HISTORY

Date: _____ Social Security No: _____

Name: _____ Address: _____
**(first, middle initial, & last)**

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Gender: M F

Business/Employer: _____Business Phone: _____

Type of Work: _____

Check One: □ Married □ Single □ Widowed □ Divorced □ Separated □ No. of Children _____

Name of Emergency Contact:_____ Phone No.: _____

Referred to this Office by: _____

Who is responsible for your bill? □ Self □ Spouse □ Workman's Comp. □ Medicaid □ Medicare

□ Auto Insurance □ Personal Health Insurance □ Other _____

Spouse's Name: _____ Employed by: _____ Business Phone: _____

## CURRENT HEALTH CONDITION

Current health problems:

1. _____
2. _____
3. _____
4. _____
5. _____

Other Doctors seen for this condition: _____
When did each condition begin?: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
What do **you** think is wrong?: _____
If disabled from work, please give dates: _____
□ Job Related □ Auto Related

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## PAST HEALTH HISTORY

*Please Check or Describe*:
Major Surgery/Operations: □ Appendectomy □ Tonsillectomy □ Gall Bladder
□ Hernia □ Broken Bones □ Hysterectomy
□ Other: _____
□ Accidents or Falls: _____
□ Fender Benders: _____
□ Have you ever been knocked unconscious? _____
□ Hospitalization (Other than above): _____
□ Have you been x-rayed in the last year? □ Yes □ No
Date and Place: _____ □ Spine □ Extremity □ Chest

Explain any extreme mental, chemical (toxic) or physical stress you have been exposed to in the past or present:
_____
_____
_____

Previous Chiropractic Care:
□ None □ Doctor's name and approximate date of last visit: _____

Have you been treated for any health condition in the last year? □ Yes □ No
If yes, please explain:
_____
_____

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## FAMILY HISTORY

Past and Present Health Problems

Mother (age) _____
Father (Age) _____
Brothers _____
Sisters _____

# PATIENT HEALTH QUESTIONNAIRE

Name: _____ Date: ___/___/___

**In the space below, please describe your major complaint. If you have an additional complaint(s), please describe on an additional page.**

1. Please describe your complaint: _____

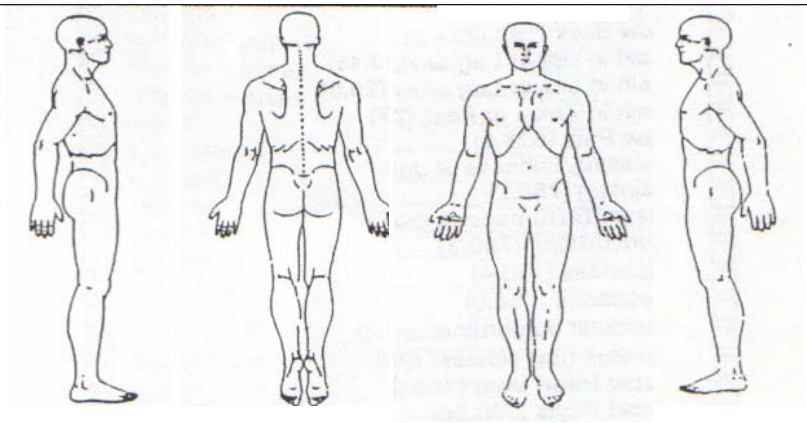
_____

_____

**a. Description:**
□ Sharp Pain
□ Dull Pain
□ Ache
□ Weak
□ Throbbing
□ Numb
□ Shooting
□ Gripping
□ Burning
□ Tingling

**b. Frequency**
□ Constant (76 – 100%)
□ Frequent (51 – 75%)
□ Occasional (26 – 50%)
□ Intermittent (25% or less)

**Mark an X on the picture where you have pain or other symptoms.**



**c. Intensity:** (circle appropriate number) No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

**d. Have your symptoms** □ decreased □ not changed □ increased

**e. Symptoms are worse in the** □ morning □ afternoon □ night
□ increases during the day □ same all day

2. a. How long has your problem been present? _____ days _____ weeks _____ months _____ years.
   b. If it followed a specific incident, please date & describe: _____

   _____
   c. If from lifting, how many lbs? ____ In what position were you? □ bent forward □ bent backwards □ knees bent □ twisted

3. What doctors/providers have you seen for this episode? □ DC □ MD □ DO □ PT
   Currently are seeing? □ DC □ MD □ DO □ PT □ None □ Other: _____
   a. Examinations included: □ X-Rays _____ (date) □ MRI _____ (date) □ CT _____ (date) □ Other _____
   Comments: _____

   b. Treatment(s) included: □ Exercise □ Heat □ Cold □ Medications □ Support □ Electrical Therapy □ Manipulation □ Surgery
   Comments: _____

4. In the past have you been treated for the same or a similar problem? □ Yes □ No If yes, when? _____
   Type of provider seen? □ DC □ MD □ DO □ PT □ Other _____

5. What makes your problem better? □ Lying Down □ Walking □ Standing □ Sitting □ Movement/Exercise □ Inactivity
6. What makes your problem worse? □ Lying Down □ Walking □ Standing □ Sitting □ Movement/Exercise □ Inactivity

7. How would you rate your general stress level? □ Little or No Stress □ Minimal Stress □ Moderate Stress □ Greatly Stressed
8. General Physical Activity: □ No regular exercise program □ Light exercise program
   □ Moderate exercise program □ Strenuous exercise program
   *If exercising, typical type of exercise being performed?* _____

9. Physical activity at work: □ Sitting more than 50% of workday □ Light manual labor
   □ Manual labor □ Heavy manual labor □ Repeated motion
10. Occupation: _____ □ Full Time □ Part Time
    Has your work status changed because of this complaint? □ Yes □ No

11. What is your current work status?
    □ Full time, no restrictions □ Part time, no restrictions □ Off work due to restrictions □ Retired □ Full time student
    □ Full time, with restrictions □ Part time, with restrictions □ Unemployed □ Full time homemaker □ Other: _____

**For Doctors Use Only**

Present complaint: _____
Date of Onset:_____ Mechanism of Onset/ADL: _____ Back Index ___
Prior Treatment and Response for this complaint: _____ Neck Index ___
Pre-Existing Status of Problem Area: _____

If you have ever had a listed condition in the past, please check it in the **Past** column. If you are presently troubled by a particular condition, check the **Present** column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

| Past | Present | | Past | Present | |
|---|---|---|---|---|---|
| □ | □ | Neck Pain (723.1) | □ | □ | Depression (311) |
| □ | □ | Shoulder Pain (719.41) | □ | □ | Aortic Aneurysm (441.5) |
| □ | □ | Pain in Upper Arm or Elbow (719.42) | □ | □ | High Blood Pressure (401.9) |
| □ | □ | Hand Pain (719.44) | □ | □ | Angina (413.9) |
| □ | □ | Wrist Pain (719.43) | □ | □ | Heart Attack (410.9) |
| □ | □ | Upper Back Pain (724.1) | □ | □ | Stroke (436) |
| □ | □ | Low Back Pain (724.2) | □ | □ | Asthma (493.9) |
| □ | □ | Pain in Upper Leg or Hip (719.45) | □ | □ | Cancer (199.1) |
| □ | □ | Pain in Lower Leg or Knee (729.5) | □ | □ | Tumor (229.9) |
| □ | □ | Pain in Ankle or Foot (719.47) | □ | □ | Prostate Problems (601.9) |
| □ | □ | Jaw Pain (526.9) | □ | □ | Blood Disorder (790.6) |
| □ | □ | Swelling/Stiffness of Joint(s) | □ | □ | Emphysema (chronic lung disorders) (492.8) |
| □ | □ | Fainting (780.2) | □ | □ | Arthritis (716.9) |
| □ | □ | Visual Disturbances (368.9) | □ | □ | Rheumatoid Arthritis (714.0) |
| □ | □ | Convulsions (780.3) | □ | □ | Diabetes (250.0) |
| □ | □ | Dizziness (780.4) | □ | □ | Epilepsy (349.5) |
| □ | □ | Headache (784.0) | □ | □ | Ulcer (556.9) |
| □ | □ | Muscular Incoordination (781.3) | □ | □ | Liver (573.9)/Gallbladder (575.9) problems |
| □ | □ | Tinnitus (Ear Noises) (388.30) | □ | □ | Kidney Stones (592.0) |
| □ | □ | Rapid Heart Beat (785.0) | □ | □ | Hepatitis (573.3) |
| □ | □ | Chest Pains (786.50) | □ | □ | Bladder Infection (595.9) |
| □ | □ | Loss of Appetite (783.0) | □ | □ | Kidney Disorders (by condition) |
| □ | □ | Anorexia (307.1) | □ | □ | Colitis (558.9) |
| □ | □ | Abnormal Weight □ Gain (783.1) □ Loss (783.2) | | | |
| □ | □ | Excessive Thirst (783.5) | □ | □ | Irritable Colon (564.1) |
| □ | □ | Chronic Cough (786.2) | □ | □ | HIV/AIDS (042) |
| □ | □ | Chronic Sinusitis (473.9) | □ | □ | Other _____ |
| □ | □ | General Fatigue (780.7) | □ | □ | Other _____ |
| □ | □ | Irregular Menstrual Flow (626.4) | | | |
| □ | □ | Profuse Menstrual Flow (626.7) | | | |
| □ | □ | Breast Soreness/Lumps (611.72) | | | |
| □ | □ | Endometriosis (617.9) | | | |
| □ | □ | PMS (625.4) | | | |
| □ | □ | Loss of Bladder Control (788.30) | | | |
| □ | □ | Painful Urination (788.1) | | | |
| □ | □ | Frequent Urination (788.41) | | | |
| □ | □ | Abdominal Pain (789.0) | | | |
| □ | □ | Constipation/Irregular Bowel Habits (564.0) | | | |
| □ | □ | Difficulty in Swallowing (787.2) | | | |
| □ | □ | Heartburn/Indigestion (787.1) | | | |
| □ | □ | Dermatitis/Eczema/Rash (692.9) | | | |

**If a family member has had any of the following please mark the appropriate box:**

□ Cancer □ Epilepsy
□ Rheumatoid Arthritis □ Chronic Back Problems
□ Diabetes □ Chronic Headaches
□ Heart Problems □ Lupus
□ Lung Problems □ Other Conditions _____
□ High Blood Pressure _____

| Yes | No | |
|---|---|---|
| □ | □ | Do you have permanent disability rating? |
| □ | □ | Location _____ |
| □ | □ | Date rating received___/___/___ |
| | | Rating Percentage _____% |

**Present: Weight** _____pounds **Height**_____feet_____inches

**Please check any of the following that apply to you:**

| Past | Present | | Past | Present | |
|---|---|---|---|---|---|
| □ | □ | Pregnancy (V22.2) | □ | □ | Tobacco (305.1) |
| □ | □ | Birth Control Pills | □ | □ | Alcohol (305.0) |
| □ | □ | Medications (list if not listed elsewhere) _____ _____ | □ | □ | Drug or Alcohol Dependence (303.9) |
| | | | □ | □ | Coffee/Tea/Caffeinated Soft Drinks: cups/cans per day _____ _____ |
| □ | □ | Hospitalization/Surgical Procedures (list if not described elsewhere) _____ | | | |

**Patient' Signature:** _____ Date: _____/_____/_____

**DOCTOR'S ADDITIONAL COMMENTS/GENERAL HEALTH CONCERNS:**

Name: _____ Date: _____/_____/_____

**DIETARY SURVEY**

Please write down the approximate number of glasses or servings of the following food items you consume each **week**.

1. whole milk _____
   skim milk _____
   cream _____
   buttermilk _____
   soy milk _____
   cheese _____
   (what kinds?) _____
   yogurt _____

2. eggs _____
   beef _____
   pork _____
   veal _____
   liver _____
   bacon _____
   fowl _____
   fish _____
   shell fish _____
   lunch meat _____
   canned meat _____

3. cereals – hot _____
   cereals – cold _____
   sugar coated _____
   pancakes _____
   waffles _____
   crackers _____
   rice-brown _____
   rice-white _____
   rice-wild _____
   macaroni _____
   spaghetti _____
   soup-canned _____
   soup-fresh _____

4. pie _____
   cake _____
   gelatin/pudding _____
   candy _____
   candy bars _____
   cookies _____
   doughnuts _____
   ice cream _____
   chips _____

5. juice _____
   (what kinds?) _____
   soda/pop _____
   spring water _____
   water-city _____
   water-well _____
   beer _____
   wine _____
   other alcohol drinks___

6. potatoes _____
   carrots _____
   beans – yellow _____
   beans – green _____
   beans – dried _____
   corn _____
   squash _____
   spinach _____
   lettuce _____
   celery _____
   green peas _____
   broccoli _____
   cauliflower _____
   asparagus _____
   onions _____
   tomatoes _____
   green peppers _____
   cabbage _____
   turnips _____
   beets _____
   others _____

7. oranges _____
   grapefruit _____
   pineapple _____
   melon _____
   apples _____
   pears _____
   bananas _____
   grapes _____
   raisins _____
   apricots _____
   peaches _____
   plums _____
   strawberries _____
   raspberries _____
   blueberries _____
   others _____

8. peanuts _____
   peanut butter _____
   other nuts _____
   jellies _____
   mayonnaise _____
   ketchup _____

9. bread slices: _____
   wheat _____
   white _____
   rye _____
   corn _____
   sweet _____
   other _____

Continued…

10. pats of:
butter _____
margarine _____

11. cups of:
coffee-regular _____
coffee-decaf _____
non-herbal tea _____
herbal tea _____

12. Number of times per week you eat out/drive through and pick up food at "fast food" restaurants? _____

**Additional Dietary Questions:**

12. What vegetable oil do you use for:
Cooking? _____ Salads? _____

13. Do you use any fats or compounds when cooking? □ yes □ no
If yes, what kinds? _____

14. How often do you use salt?
□ Freely □ Moderately □ Sparingly □ Never

15. How often do you use vinegar
□ Freely □ Moderately □ Sparingly □ Never

16. If you add sugar to tea, coffee, or other foods at the table; about how many teaspoonfuls do you add each day? _____

17. Do the answers on this survey reflect your average diet over the past three years? □ yes □ no
Comments: _____

18. What foods, if any, disagree with you?
_____

19. Do you experience indigestion? □ yes □ no If yes, how frequently? _____

20. What did you have for breakfast yesterday?
_____

21. What did you have for lunch yesterday?
_____

22. What did you have for dinner/supper yesterday?
_____

23. What beverages did you drink yesterday?
_____

24. Did you eat any food or drink any beverages between meals? □ yes □ no

25. Are you fond of:

| | | |
|---|---|---|
| meats | □ yes | □ no |
| fruits | □ yes | □ no |
| vegetables | □ yes | □ no |
| breads | □ yes | □ no |
| cereals | □ yes | □ no |
| sweets | □ yes | □ no |
| fats | □ yes | □ no |
| butter | □ yes | □ no |

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**For Doctors Use Only:**

**COMPLETE CHIROPRACTIC, INC**
**Dr. Grant L. Modory, D.C. ♏ 303 Hester St. W. ♏ Dundas, MN 55019 ♏ (507) 645-0333**

## PURPOSE

The purpose of our chiropractic center is to support each individual in achieving their optimum health and to educate them so that they may understand health and chiropractic and in turn educate others.

## INFORMATION ABOUT APPLIED KINESIOLOGY AND CONTACT REFLEX ANALYSIS IN MINNESOTA

The Doctors of Chiropractic in this office have received education and training in the use of Applied Kinesiology (AK) and Contact Reflex Analysis (CRA) to assist in evaluating your body's nervous system. The practice of the AK was started by Dr. George Goodheart of Detroit, MI in 1964; while the practice of CRA was started by Dr. D.A. Versendaal of Holland, MI in 1962.

AK and CRA are utilized in other healing sciences. Some Doctors of Medicine, Optometry, and Dentistry and nurses have been trained in AK and CRA and use it to gain better insight in to body function. AK and CRA are not widely available.

While there has been some research and publications of AK and CRA in professional journals, some so the techniques of AK and CRA have not been supported by a body of evidence using standard scientific research and methodologies.

This office utilizes standard chiropractic testing procedures for diagnosing with additional support from AK and CRA.

I hereby agree to an examination utilizing standard testing procedures, AK and CRA. I also agree to treatment and therapy as agreed upon by the patient and Doctor.

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## AGREEMENT AND RELEASE

I authorize release of information to family physicians, my employer and/or insurance companies. I authorize the taking of photographs and x-rays to be used for treatment purposes. I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself and that, ultimately, I am financially responsible for all services rendered. I also understand that if I terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I authorize my insurance benefits to be paid directly to Grant Modory, D.C. Yes ___ No ___

**Patient's Signature _____ Date _____**

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Your appointment is a reservation of time. *If you cannot make your appointment, please give us 24 hours advance notice so that someone else may use it for their health needs*. If you do not notify us, a fee of ½ our regular visit charge will be assessed to your account.

I have read and I fully understand ALL of the above.

**Patient's signature _____ Date _____**

**Office Verification Signature _____ Date _____**

# Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information (PHI) we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

Signature of Patient Date