Welcome to our office! We are sure that you will be provided the most appropriate and professional chiropractic care possible. Our most important goal is the constant improvement and maintenance of your health. Before we get started with today's examination procedures, which will determine how we can help you, we want you to understand what we do and why we are going to do it.

The goal of our office is to allow your body to function at its highest potential, free from interference and stress that causes dysfunction, disease, and eventually symptoms and sickness. When a person seeks chiropractic care and when a chiropractor accepts a patient for such care, it is essential that they are both working towards the same goals.

Most importantly, you must understand that chiropractic is not a substitute for medical treatment of any kind, in anyway, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to get rid of whatever symptoms or conditions are bothering them. This is symptom, sickness, and disease care, and it is necessary in emergency situations. Chiropractic recognizes that you get symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is true healthcare, focusing on the optimum function of the individual, and it's what we do in our office.

The purpose of chiropractic is to restore and maintain the integrity of the spine, spinal cord, and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine called vertebrae. Misalignments of those vertebrae, which interfere with transmission of normal nerve impulses, are called SUBLUXATIONS. Subluxations are the most common cause of nerve system interferences (pinched nerves) and cause dysfunction to the tissues and organs that these nerves supply.

With appropriate chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nervous system is the foundation to good health.

The information we get from you is important. We use your health history, x-rays, computerized muscle assessment, and palpatory examination to locate subluxations. For this reason, please fill out our history forms completely and to the best of your ability. It will save us from doing unnecessary tests and give us the most accurate information.

Please feel free to ask any questions at any time to the staff or doctors in our office and again, welcome. We look forward to a healthy relationship with you and your family.

Sincerely,

Dr. Justin & Woodbury Spine Staff ☺

ADULT MEMBER HEALTH RECORD

ABOUT YOU

NAME:	
ADDRESS:	
CITY:	STATE/ZIP CODE:
HOME PHONE:	CELL PHONE:
EMAIL ADDRESS:	
DATE OF BIRTH:	AGE:
MARITAL STATUS:	# OF CHILDREN:
EMPLOYER'S NAME:	
EMPLOYER'S ADDRESS:	
WORK PHONE:	POSITION TITLE:
INSURANCE COMPANY:	
INSURED'S NAME:	
INSURED'S DATE OF BIRTH:	

ABOUT YOUR SPOUSE

SPOUSE'S NAME:	
ADDRESS:	
CITY:	ZIP CODE:
HOME PHONE:	CELL PHONE:
SPOUSE'S EMPLOYER'S NAME:	
EMPLOYER'S ADDRESS:	ZIP CODE:
EMPLOYER'S CITY/STATE:	POSITION TITLE:

HEALTH HABITS

DO YOU SMOKE? ___YES ___NO HOW OFTEN? _____
DO YOU DRINK ALCOHOL? ___YES ___NO HOW OFTEN? _____
DO YOU DRINK COFFEE, TEA, OR SODA? ___YES ___NO

DO YOU EXERCISE REGULARLY? ___YES ___NO
IF YES, HOW OFTEN? _____
IF NO, IS THAT SOMETHING YOU'D LIKE TO IMPROVE? _____

DO YOU WEAR:
___ARCH SUPPORTS
___HEAL LIFTS ___ SOLE LIFTS ___INSOLES

WOODBURY SPINE WELLNESS CENTER
A COMMUNITY INSPIRED BY WELLNESS

8147 GLOBE DRIVE
SUITE 100
WOODBURY, MN 55125
651-731-0505 (OFFICE)
651-731-0500 (FAX)

CHIROPRACTIC EXPERIENCE

WHO REFERRED YOU TO OUR OFFICE?

DID YOU SEE OR HEAR OF OUR OFFICE BECAUSE OF (CHECK ALL THAT APPLY):
___NEWSPAPER ___SIGN ___YELLOW PAGES
___MAILING ___COMMUNITY EVENT ___OTHER_____

HAVE YOU BEEN ADJUSTED BY A CHIROPRACTOR BEFORE? ___YES ___NO

IF YES, WHAT WAS THE REASON FOR THOSE VISITS?

DOCTOR OF CHIROPRACTIC'S NAME:

APPROXIMATE DATE OF LAST VISIT:

HAS ANY ADULT IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

HAS ANY CHILD IN YOUR FAMILY EVER SEEN A CHIROPRACTOR?

REASON FOR THIS VISIT

DESCRIBE THE REASON FOR THIS VISIT:

IS THE PURPOSE OF THIS APPOINTMENT RELATED TO:
___CHRONIC DISCOMFORT ___HOME INJURY
___SPORTS ___AUTO ___FALL ___OTHER
PLEASE EXPLAIN:

IF JOB RELATED, HAVE YOU MADE A REPORT OF YOUR ACCIDENT TO YOUR EMPLOYER? ___YES ___NO

WHEN DID THIS CONDITION BEGIN?

HAS THIS CONDITION:
___GOTTEN WORSE ___STAYED CONSTANT
___COME AND GONE

DOES THIS CONDITION INTERFERE WITH :
___SLEEP ___DAILY ROUTINE ___OTHER ACTIVITIES
PLEASE EXPLAIN:

HAS THIS CONDITION OCCURRED BEFORE? ___YES ___NO
PLEASE EXPLAIN:

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION?
___YES ___NO

NAME(S) OF DOCTOR(S):

TYPES OF TREATMENTS:

RESULTS:

ARE YOU AWARE THAT:

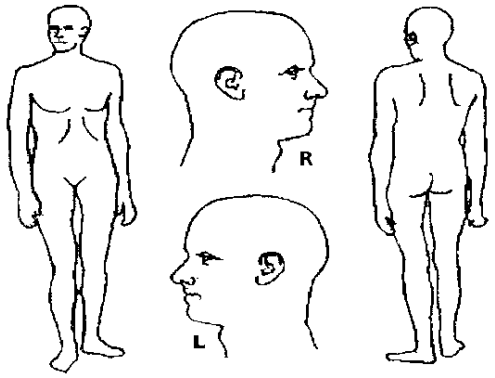
DOCTORS OF CHIROPRACTIC WORK WITH THE NERVOUS SYSTEM?	___YES ___NO
CHIROPRACTIC IS THE LARGEST NATURAL HEALING PROFESSION IN THE WORLD?	___YES ___NO
THE NERVOUS SYSTEM CONTROLS ALL BODILY FUNCTIONS AND SYSTEMS?	___YES ___NO
IF CHIROPRACTIC CARE STARTS AT BIRTH, ONE CAN ACHIEVE A HIGHER LEVEL OF HEALTH THROUGHOUT LIFE?	___YES ___NO

MEDICATIONS YOU TAKE

___CHOLESTEROL	___BLOOD PRESSURE	___STIMULANTS
___BLOOD THINNERS	___TRANQUILIZERS	___PAIN KILLERS
___ASPIRIN/ETC.	___MUSCLE RELAXERS	___INSULIN
___OTHER (list below)	___OTHER (list below)	___OTHER (list below)

___VITAMINS & SUPPLEMENTS:

MARK AREAS OF PAIN WITH AN "X"



YOUR CONCERNS

INSTRUCTIONS: Please circle the health concerns or conditions you may be experiencing now or have had in the past. Each area of concern relates to an area of the spine and nerve functions.

C1
C2
C3
C4

HEADACHES
MIGRAINES
DIZZINESS
SINUS PROBLEMS
ALLERGIES
FATIGUE
HEAD COLDS
VISION PROBLEMS
DIFFICULTY CONCENTRATING
HEARINGPROBLEMS

SORE THROAT
STIFF NECK
RADIATING ARM PAIN
HAND/FINGER NUMBNESS
ASTHMA
ALLERGIES
HIGH BLOOD PRESSURE
HEART CONDITIONS

C5
C6
C7
T1

T2
T3
T4
T5
T6
T7
T8
T9

MIDDLE BACK PAIN
CONGESTION
DIFFICULTY BREATHING
BRONCHITIS
PNEUMONIA
GALLBLADDER CONDITONS
STOMACH PROBLEMS
ULCERS
GASTRITIS
KIDNEY PROBLEMS

CONSTIPATION
COLITIS
DIARRHEA
GAS PAIN
IRRITABLE BOWEL
BLADDER PROBLEMS
MENSTRUAL PROBLEMS
LOW BACK PAIN
PAIN OR NUMBNESS IN LEGS
REPRODUCTIVE ISSUES

L1
L2
L3
L4
L5
S
A
C
R
A
L

OTHER:
_____
_____
_____
_____

HEALTH CONDITIONS

INSTRUCTIONS: *Please check each of the diseases or conditions that you have now or have had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan, and possibility of being accepted for care.*

□ SEVERE OR FREQUENT HEADACHES	□ THYROID PROBLEMS	□ PAIN IN ARMS/LEGS/HANDS	□ NUMBNESS
□ HEART SURGERY/PACEMAKER	□ SINUS PROBLEMS	□ LOW BLOOD PRESSURE	□ ALLERGIES
□ LOWER BACK PROBLEMS	□ HEPATITIS	□ RHEUMATIC FEVER	□ DIABETES
□ DIGESTIVE PROBLEMS	□ DIFFICULTY BREATHING	□ ULCERS/COLITIS	□ SURGERIES:
□ PAIN BETWEEN SHOULDERS	□ KIDNEY PROBLEMS	□ TUBERCULOSIS	□ ASTHMA
□ CONGENITAL HEART DEFECT	□ HIGH BLOOD PRESSURE	□ ARTHRITIS	□ LOSS OF SLEEP
□ FREQUENT NECK PAIN	□ CHEMOTHERAPY	□ SHINGLES	□ DIZZINESS

FOR WOMEN ONLY:

ARE YOU PREGNANT?
___YES ___NO

IF YES, WHEN IS YOUR DUE DATE? _____

ARE YOU NURSING?
___YES ___NO

WOODBURY SPINE WELLNESS CENTER
A Community Inspired by Wellness

8WAY 8 weeks to wellness
Give us 8 weeks and we'll change the rest of your life®

The Wellness Score™

Medical Symptoms Questionnaire (MSQ)

Name: _____ Date: _____
Email Address: _____
Rate each of the following symptoms based upon your typical health profile for the **past 30 days**.

Point Scale
0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

Head _____ Headaches _____ Faintness _____ Dizziness _____ Insomnia **Total** _____	**Energy/ Activity** _____ Fatigue, Sluggishness _____ Apathy, Lethargy _____ Hyperactivity _____ Restlessness **Total** _____	**Lungs** _____ Chest Congestion _____ Asthma, Bronchitis _____ Shortness of Breath _____ Difficulty Breathing **Total** _____
Eyes _____ Watery or Itchy Eyes _____ Swollen, Reddened or Sticky Eyelids _____ Bags or Dark Circles Under Eyes _____ Blurred or Tunnel Vision (does not include near or far-sightedness) **Total** _____	**Weight** _____ Binge Eating/Drinking _____ Craving Certain Foods _____ Excessive Weight _____ Compulsive Eating _____ Water Retention _____ Underweight **Total** _____	**Heart** _____ Irregular or Skipped Heartbeat _____ Rapid or Pounding Heartbeat _____ Chest Pain **Total** _____
Ears _____ Itchy Ears _____ Earaches, Ear Infections _____ Drainage from Ear _____ Ringing in Ears, Hearing Loss **Total** _____	**Emotions** _____ Mood Swings _____ Anxiety, Fear, Nervousness _____ Anger, Irritability, Aggressiveness _____ Depression **Total** _____	**Digestion** _____ Nausea, Vomiting _____ Diarrhea _____ Constipation _____ Bloated Feeling _____ Belching, Passing Gas _____ Heartburn _____ Intestinal/Stomach Pain **Total** _____
Nose _____ Stuffy Nose _____ Sinus Problems _____ Hay Fever _____ Sneezing Attacks _____ Excessive Mucus Formation **Total** _____	**Mind** _____ Poor Memory _____ Confusion, Poor Comprehension _____ Poor Concentration _____ Poor Physical Condition _____ Difficulty in Making Decisions _____ Stuttering or Stammering _____ Slurred Speech _____ Learning Disabilities **Total** _____	**Skin** _____ Acne _____ Hives, Rashes, Dry Skin _____ Hair Loss _____ Flushing, Hot Flashes _____ Excessive Sweating **Total** _____
Mouth/Throat _____ Chronic Coughing _____ Gagging, Frequent Need to Clear Throat _____ Sore Throat, Hoarseness, Loss of Voice _____ Swollen or Discolored Tongue, Gums, or Lips _____ Canker Sores **Total** _____	**Joints/Muscles** _____ Pain or Aches in Joints _____ Arthritis _____ Stiffness or Limitation of Movement _____ Pain or Aches in Muscles _____ Feeling of Weakness or Tiredness **Total** _____	**Other** _____ Frequent Illness _____ Frequent or Urgent Urination _____ Genital Itch or Discharge **Total** _____ **Grand Total** _____

***On a scale of 0 to 10 with 0 = Worst and 10 = Best, rate how well you think you are doing with the following:**

Exercise____ Sleep____ Diet____ Stress Level____ Water Intake____

WOODBURY SPINE
WELLNESS CENTER

PLATINUM	GOLD	SILVER
8 WEEKS TO WELLNESS AS A WELLNESS PATIENT I WANT THE ULTIMATE OPPORTUNITY TO BE WELL. MY GOALS ARE TO HAVE A HEALTHY NERVOUS SYSTEM THAT IS FREE OF INTERFERENCE AND PAIN. I WANT TO LOSE WEIGHT AND GAIN ENERGY BY DOING IN-OFFICE WORKOUTS AND MASSAGES. PLUS, I WANT TO KNOW HOW TO STAY CHEMICALLY HEALTHY BY LEARNING HOW TO EAT RIGHT AND STILL ENJOY MY LIFESTYLE. I WANT TO CHANGE MY LIFE AND HAVE THE LIFE I HAVE ALWAYS WANTED. I WANT **8 WEEKS TO WELLNESS!**	**CHIROPRACTIC CARE** (SLIGHT INTEREST IN WELLNESS) AS A PATIENT YOUR FIRST CONCERN IS TO ADDRESS THE HEALTH OF YOUR NERVOUS SYSTEM THROUGH CHIROPRACTIC AND ONCE YOUR NERVOUS SYSTEM IS HEALTHIER, YOUR NEXT DESIRE IS TO LOOK AT WAYS TO ACHIEVE THE ULTIMATE HEALTHY LIFESTYLE THROUGH 8 WEEKS TO WELLNESS AND ITS COMPONENTS.	**STANDARD** AS A CHIROPRACTIC PATIENT YOU WILL EXPERIENCE LIFE THROUGH A NEW HEALTHY NERVOUS SYSTEM. YOUR **GOALS** ARE TO GO THROUGH THREE PHASES OF CARE TO A HEALTHIER NERVOUS SYSTEM, BY ELIMINATING YOUR BODY'S MALFUNCTION, CORRECTING THE SUBLUXATIONS THAT EXIST IN YOUR SPINE, AND MAINTAINING THEM THROUGH FULL SPECTRUM CHIROPRACTIC.
_____	_____	_____

PLACE AN "X" ON THE LINE BELOW THE CHOICE THAT BEST DESCRIBES YOUR HEALTH GOALS

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 enforcement activities. Any other disclosure for the purposes of treatment, payment, or practice parathion will be made only after obtaining your consent:

- You may request restrictions on your disclosures.
- You may inspect and receive 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 indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations 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 or disclosed.

PATIENT'S NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An **adjustment** is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental, and social well being, not merely the absence of disease.

Vertebral subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health. We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any question regarding the doctor's objectives pertaining to my care in this office has been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

SIGNATURE:	DATE:
WITNESS' SIGNATURE:	DATE:

PAYMENT AGREEMENT/USE OF INSURANCE AUTHORIZATION

I hereby authorize the Doctors of Woodbury Spine Wellness Center to work with my condition through the use of adjustments to my spine, as he/she deems appropriate. I clearly understand and agree that all services rendered by 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. Woodbury Spine Wellness Center will not be held responsible for any preexisting 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 by me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to Woodbury Spine Wellness Center, LLC for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Woodbury Spine Wellness Center will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Woodbury Spine Wellness Center, LLC will be credited to my account upon receipt.

Signature:	Date:
Guardian or Spouse Authorizing Care's Signature:	Date:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

□ PATIENT □ SPOUSE □ PARENT □ WORKERS COMP □ AUTO INSURANCE

□ MEDICARE □ HEALTH INSURANCE

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors in the chiropractic office and whomever they may designate as their assistant to administer chiropractic care to my child through the use of adjustments and procedures the doctor deems appropriate such as mobility, massage, and any therapy the doctor seems appropriate as discussed with parent. I clearly understand and agree that all services rendered by my child 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. Nye will not be held responsible for any pre-existing medically diagnosed condition or for any medical diagnosis. I also understand if I suspend or terminate my child's care for any reason, any fees for professional services rendered will become immediately due and payable. I hereby authorize assignment of my child's insurance rights and benefits (if applicable) directly to the provider for services rendered. I authorize the use of this signature to allow the insurance company to pay Woodbury Spine Wellness Center, LLC directly any amount payable as my child's assignment of benefits. I authorize the use of this signature on any insurance submissions.

NAME OF CHILD:_____ **BIRTHDATE:**_____

PARENT OR GUARDIAN AUTHORIZING CARE'S SIGNATURE:_____

Woodbury Spine Wellness Center

8147 Globe Drive Suite 100, Woodbury, MN 55042 651-731-0505

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524