Red Rock Chiropractic Center

New Patient Form (Ages 5-17)

OFFICE USE ONLY
☐Demographics ☐Insurance
☐Vitals
Height_____
Weight_____
BP_____
Pulse_____
Shoe Size_____

PATIENT INFORMATION

Title: ☐Mr. ☐Miss **Sex:** ☐M ☐F
First name: _____**Middle Name:**_____
Last name: _____**Suffix:**_____
Preferred name (Nickname):_____
Age: _____ **Birth date:** ___/___/_____
Address: _____
City: _____ **State:**_____ **Zip:** _____
Primary phone: (____)_____ - _____
Secondary phone: (____) _____ - _____
Mobile phone: (____) _____ - _____
Parent Home Email:_____
Parent Work Email: _____
Best Contact Method: ☐Primary Phone ☐Secondary Phone ☐Mobile Phone ☐Home Email ☐Work Email
We are required to send you a summary after each office visit. What email address do you prefer to have this communication sent to from this office? ☐Home Email ☐Work Email ☐Other_____

FAMILY INFORMATION

Mother's name:_____
Mother's cell phone:_____
Mother's employer:_____
Mother's work phone:_____
Father's name:_____
Father's cell phone:_____
Father's employer:_____
Father's work phone:_____
Siblings names and ages _____
_____

EMERGENCY CONTACT INFORMATION

Emergency contact name: _____
Emergency contact phone: (___)____-_____
Emergency contact alternate phone: (___)____-_____
Relationship to patient: _____

SCHOOL & HOBBIES

Current school_____
Current grade in school_____
Special services currently being received in school or privately
_____
_____
Favorite Hobbies or Interests:_____
_____
_____

PRIMARY CARE PHYSICIAN

Primary care physician name:_____
Clinic name:_____
City:_____ Phone: (___)____-_____

REFERRAL SOURCE

How did you hear about us?
☐Website ☐Newspaper ☐Phone book ☐Radio_____
☐Physician_____☐Massage therapist_____
☐Referral _____

PRIMARY INSURANCE INFORMATION

Insurance company: _____
Policyholder name: _____
Relationship to patient: _____
Policy number: _____
Group number: _____
Person responsible for payment: _____
Deductible: _____ Amt met this year: _____Co-pay: _____

SECONDARY INSURANCE INFORMATION

Insurance company: _____
Policyholder name: _____
Relationship to patient: _____
Policy number: _____
Group number: _____
Person responsible for payment: _____
Deductible: _____ Amt met this year: _____Co-pay: _____

Health Questionnaire

Please mark the conditions for which you would like to be seen today.

☐Headaches ☐Jaw pain ☐Neck pain ☐Shoulder pain ☐Arm pain ☐Wrist pain ☐Hand pain ☐Upper back pain ☐Mid back pain
☐Lower back pain ☐Hip pain ☐Leg pain ☐Ankle pain ☐Foot pain ☐Other_____

Other Treatment

Please list any other treatments you have received and the providers you have seen for these conditions.

☐Chiropractic _____ ☐Neurology_____ ☐Massage_____
☐Medication_____ ☐Physical therapy_____ ☐Surgery _____
☐Other_____

Accidents, Injuries, Fractures, & Hospitalizations

Please list any previous accidents, injuries, fractures, and hospitalizations and approximate date of occurrence.

Accident & Date	Injury & Date	Fracture & Date	Hospitalization & Date
☐No previous accidents	☐No previous injuries	☐No previous fractures	☐No previous hospitalizations
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4	4	4.	4

Diagnostic Imaging

Please mark any diagnostic imaging and approximate date of occurrence.

X-ray & Date	MRI & Date	CT Scan & Date	Bone Density & Date
☐No previous x-rays	☐No previous MRIs	☐No previous CT Scans	☐No previous bone densities
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4	4	4.	4

Surgeries

Please mark any previous surgeries and list the approximate date of occurrence.

Surgery	Date	Surgery	Date
☐No previous surgeries		☐Laminectomies	
☐Appendectomy		☐Prostate surgery	
☐Cardiovascular procedure		☐Radical prostatectomy	
☐Cervical disc procedure		☐Other _____	
☐C-section		☐Other _____	
☐Gall bladder		☐Other _____	
☐Hysterectomy		☐Other _____	
☐Joint replacement		☐Other _____	

General Health History

Please answer the following questions:

What was the date of last physical examination: ____/____/_____
Have you ever been to a chiropractor before? ☐Yes ☐No
Have you had an x-ray or CT scan or MRI of your low back spine in the past **28 days**? ☐Yes ☐No
Has any doctor diagnosed you with Hypertension (high blood pressure) presently**?** ☐Yes ☐No **If yes, what kind**? ☐Primary ☐secondary
Has any doctor diagnosed you with Diabetes presently**?** ☐Yes ☐No **If yes, what kind?** ☐Type I (Juvenile Onset) ☐ Type 2 (Adult Onset)
If yes, was your blood lab-work test for hemoglobin A1c>9.0% ☐Yes ☐No ☐Not sure
Has any doctor diagnosed you with any type of significant health syndrome presently? ☐Yes ☐No ☐Not sure
If yes, what kind? _____

STRESS

What is your daily stress level: 0 1 2 3 4 5 6 7 8 9 10 N/A
Have you ever sought help for a mental health issue? ☐Yes ☐No

SMOKING HISTORY

Do you currently smoke tobacco of any kind?: (check one) ☐Yes ☐Never been a smoker ☐Former smoker
If yes, how often do you smoke? ☐Current everyday smoker ☐Current somedays smoker
If yes, how much do you smoke? ☐Less than 1 pack a day ☐1 pack a day ☐More than 1 pack a day
If yes, what is your level of interest in quitting smoking? 0 1 2 3 4 5 6 7 8 9 10 N/A

SLEEPING PATTERN

How many hours of sleep do you get per night? 0 1 2 3 4 5 6 7 8 9 10 N/A
What is your sleep quality? ☐Excellent ☐Good ☐Fair ☐Poor
How many times per night is your sleep interrupted? 0 1 2 3 4 5 6 7 8 9 10 N/A

NUTRITION

Please let us know if you are interested in learning more about nutritional supplements or wellness care which can help with the following health concerns. Please mark the topics you would like to discuss.

☐General Wellbeing ☐Joint Health ☐Bone Health ☐Pain & Inflammation/Injury Recovery ☐Immune Support ☐Heart Health
☐Gastro Intestinal Health (Digestion) ☐Increased Athletic Performance ☐Women's Health (UTIs, Menopause, Pre-natal, PMS)
☐Men's Health (Prostrate) ☐Children's Health

Please list any current special dietary needs: ☐No special dietary needs

_____

_____

WEIGHT LOSS /EXERCISE

Are you interested in weight loss? ☐Yes ☐No
Are you interested in an exercise program? ☐Yes ☐No

Current Medications/Vitamins

Please list current medications and vitamins including dosage, if known.

☐I am currently not taking any medications.

Medication Name	Dosage & Frequency	Medication Name	Dosage & Frequency
1.		5.	
2.		6.	
3.		7.	
4		8.	

Medication Allergies

Please list any known allergies that you have to any medications.

☐I have no known medication allergies.

1.	3.
2.	4.

Non-medication Allergies

Please list any known allergies that you have.

☐I have no known allergies.

1.	3.
2.	4.

Women Only

Are you pregnant? ☐Yes ☐No ☐Unsure If pregnant, what is your due date? ____/____/_____

Social History

Caffeine used ☐Often ☐Occasionally ☐Never	**Chew tobacco** ☐Often ☐Occasionally ☐Never	**Wear seatbelt** ☐Always ☐Usually ☐Never
Drink alcohol ☐Often ☐Occasionally ☐Never	**Exercise** ☐Often ☐Occasionally ☐Never	

Family History

Alzheimer's ☐Parent ☐Sibling	Diabetes ☐Parent ☐Sibling	Osteoporosis ☐Parent ☐Sibling
Arthritis ☐Parent ☐Sibling	Epilepsy ☐Parent ☐Sibling	Psychiatric ☐Parent ☐Sibling
Cholesterol ☐Parent ☐Sibling	Heart problems ☐Parent ☐Sibling	Stroke ☐Parent ☐Sibling
Cancer ☐Parent ☐Sibling	High blood pressure ☐Parent ☐Sibling	Thyroid ☐Parent ☐Sibling

Substance Use

Alcohol ☐Past ☐Present	Cocaine ☐Past ☐Present	Marijuana ☐Past ☐Present
Amphetamines ☐Past ☐Present	Crystal Meth ☐Past ☐Present	Other_____ ☐Past ☐Present
Barbiturates ☐Past ☐Present	Heroin ☐Past ☐Present	

Recreational Activities

☐Backpacking	☐Gymnastics	☐Swimming
☐Baseball	☐Hockey	☐Tennis
☐Basketball	☐Hunting	☐Track
☐Biking	☐Racket ball	☐Volleyball
☐Boating	☐Running	☐Walking
☐Fishing	☐Skiing	☐Weight lifting
☐Football	☐Soccer	☐Wrestling
☐Golf	☐Softball	☐Other_____
Do you carry a back pack? ☐Yes ☐No	How many hours per day do you watch TV? _____	How many hours per day do you play computer games? _____

MEDICAL HISTORY

Please indicate if you have ever experienced or have been diagnosed as having any of the following:

Abdominal pain	☐Past ☐Present	Double vision	☐Past ☐Present	Ovarian cysts	☐Past ☐Present
Acne	☐Past ☐Present	Drowning	☐Past ☐Present	Panic attacks	☐Past ☐Present
ADD/ADHD	☐Past ☐Present	Dyslexia	☐Past ☐Present	Paranoia	☐Past ☐Present
Allergy shots	☐Past ☐Present	Ear pain	☐Past ☐Present	Passive/aggressive behavior	☐Past ☐Present
Anemia	☐Past ☐Present	Easy bleeding	☐Past ☐Present	Peeling	☐Past ☐Present
Anger	☐Past ☐Present	Easy bruising	☐Past ☐Present	Pinched nerves	☐Past ☐Present
Animal bites	☐Past ☐Present	Eczema	☐Past ☐Present	Pinkeye	☐Past ☐Present
Anxiety disorder	☐Past ☐Present	Energy level problem	☐Past ☐Present	Pneumonia	☐Past ☐Present
Arthritis	☐Past ☐Present	Epilepsy	☐Past ☐Present	Poison ivy (oak, sumac)	☐Past ☐Present
Asthma	☐Past ☐Present	Eye injury	☐Past ☐Present	Poor coordination	☐Past ☐Present
Athlete's foot	☐Past ☐Present	Eyestrain	☐Past ☐Present	Poor posture	☐Past ☐Present
Autism/Autism spectrum disorder	☐Past ☐Present	Fainting	☐Past ☐Present	Post nasal drip	☐Past ☐Present
Bed wetting	☐Past ☐Present	Fatigue	☐Past ☐Present	Premenstrual syndrome	☐Past ☐Present
Bipolar disorder	☐Past ☐Present	Fevers/chills/sweats	☐Past ☐Present	Psoriasis	☐Past ☐Present
Blacking out	☐Past ☐Present	Foul odor of urine	☐Past ☐Present	Rashes	☐Past ☐Present
Blood in urine	☐Past ☐Present	Fractured jaw	☐Past ☐Present	Repetitive motion injury	☐Past ☐Present
Bloody stools	☐Past ☐Present	Frequent colds	☐Past ☐Present	Rheumatic fever	☐Past ☐Present
Bone pain	☐Past ☐Present	Frequent headaches	☐Past ☐Present	Ringing in ears	☐Past ☐Present
Bowel problems	☐Past ☐Present	Frequent urination	☐Past ☐Present	Scoliosis	☐Past ☐Present
Braces	☐Past ☐Present	Frostbite	☐Past ☐Present	Seizures/Convulsions	☐Past ☐Present
Breathing problems	☐Past ☐Present	Glasses/contacts	☐Past ☐Present	Self-esteem issues	☐Past ☐Present
Brittle nails	☐Past ☐Present	Growing pains	☐Past ☐Present	Sensitivity to light	☐Past ☐Present
Broken bones	☐Past ☐Present	Hay fever	☐Past ☐Present	Serious fall(s) or repetitive falls	☐Past ☐Present
Broken/knocked out teeth	☐Past ☐Present	Head injury	☐Past ☐Present	Severe headaches	☐Past ☐Present
Bronchitis	☐Past ☐Present	Hearing loss	☐Past ☐Present	Shortness of breath	☐Past ☐Present
Burning urination	☐Past ☐Present	Heart disease	☐Past ☐Present	Sinus problems	☐Past ☐Present
Burns	☐Past ☐Present	Heat exhaustion/heat stroke	☐Past ☐Present	Skin ulcers	☐Past ☐Present
Changes in moles	☐Past ☐Present	Hiccups	☐Past ☐Present	Sleep problems	☐Past ☐Present
Chemical insensitivities	☐Past ☐Present	Hyperventilation	☐Past ☐Present	Sleeping disorders	☐Past ☐Present
Chicken pox	☐Past ☐Present	Hypoglycemia (low blood sugar)	☐Past ☐Present	Snoring	☐Past ☐Present
Choking	☐Past ☐Present	Illnesses accompanied by a high fever	☐Past ☐Present	Sore throat	☐Past ☐Present
Chronic ear infections/earaches	☐Past ☐Present	Ingrown toenails	☐Past ☐Present	Spinning/balance	☐Past ☐Present
Chronic fatigue	☐Past ☐Present	Insect stings	☐Past ☐Present	Sports injury	☐Past ☐Present
Cold sores	☐Past ☐Present	Insomnia	☐Past ☐Present	Sprains/strains	☐Past ☐Present
Concussion	☐Past ☐Present	Itching	☐Past ☐Present	Suicidal thoughts	☐Past ☐Present
Constipation	☐Past ☐Present	Jaw pain	☐Past ☐Present	Sunburn	☐Past ☐Present
Corns and calluses	☐Past ☐Present	Joint pain	☐Past ☐Present	Swelling	☐Past ☐Present
Cough/Wheezing	☐Past ☐Present	Joint stiffness	☐Past ☐Present	Swollen glands	☐Past ☐Present
Coughing of phlegm	☐Past ☐Present	Lazy eye	☐Past ☐Present	Tingling sensations	☐Past ☐Present
Coughing up blood	☐Past ☐Present	Lice	☐Past ☐Present	Tourette's syndrome	☐Past ☐Present
Cross eye	☐Past ☐Present	Lower side pain	☐Past ☐Present	Toxic shock syndrome	☐Past ☐Present
Croup	☐Past ☐Present	Meningitis	☐Past ☐Present	Trouble sleeping through the night	☐Past ☐Present
Cuts, scrapes, punctures	☐Past ☐Present	Menstrual cramps	☐Past ☐Present	Trouble with bladder control (enuresis)	☐Past ☐Present
Deformity	☐Past ☐Present	Menstrual problems	☐Past ☐Present	Unconsciousness	☐Past ☐Present
Dehydration	☐Past ☐Present	Mood swings	☐Past ☐Present	Unusual stress	☐Past ☐Present
Depression	☐Past ☐Present	Muscle ache	☐Past ☐Present	Urinary infection	☐Past ☐Present
Diarrhea	☐Past ☐Present	Muscle weakness	☐Past ☐Present	Vaginal yeast infection	☐Past ☐Present
Difficulty urinating	☐Past ☐Present	Neck or back problems	☐Past ☐Present	Visual impairment	☐Past ☐Present
Difficulty walking	☐Past ☐Present	Neurological disorders	☐Past ☐Present	Warts	☐Past ☐Present
Digestive disorders	☐Past ☐Present	Nosebleed	☐Past ☐Present	Weakness	☐Past ☐Present
Dislocations	☐Past ☐Present	Numbness	☐Past ☐Present	Weight loss/gain	☐Past ☐Present
Dizziness	☐Past ☐Present	Obsessive compulsive disorder	☐Past ☐Present	Other: _____	☐Past ☐Present

Number of doses of antibiotics taken in the past 6 months: _____	Total number of doses of antibiotics taken total during: _____	Adverse reaction to any vaccinations (even if mild) If Yes, please explain: _____
Number of doses of other prescription medications taken in the past 6 months: _____	Total number of doses of other prescription medications during lifetime: _____	

Consent to Treat a Minor

(for patients 17 years of age and younger)

I hereby request and authorize Dr. Kyle Pankonin to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter_____.
This authorization is also intended to include radiographic examination at the doctor's discretion.
As of this date, I have the legal right to select and authorize health care services for the minor child above.

(If applicable) Under the terms and conditions of my divorce, separation, and/or other legal authorization, the consent of a spouse, former spouse, or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

HIPAA Privacy Act

I have received RRCC, notice of HIPAA Privacy Act. I authorize RRCC to release to my insurance company, health plan, HMO, no-fault carrier, and/or workers' compensation carrier, any information including my complete health record needed to determine benefits for services provided by or on behalf of RRCC. I understand and agree that I am financially responsible to RRCC, for any and all charges not covered by insurance for myself, spouse, and dependents.

_____ _____

Patient or Legal Guardian Signature **Date**

Consent to Electronic Communication

I acknowledge the privacy risks associated with using Electronic communications and authorize Red Rock Chiropractic Center staff and/or doctor to communicate with me or any minor dependent/ward for purpose of medical advice, education, clinical record summaries, full medical records, and/or appointment reminders. I understand that my e-mail address will not be given to anyone outside of this clinic for any reason and that this will be for medical purposes only.

_____ _____

Patient or Legal Guardian Signature **Date**

Insurance Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Red Rock Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature **Date**

I request that payment of authorized Medicare benefits be made of my behalf to Red Rock Chiropractic Center for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Responsible Party Signature **Date**

AUTHORIZATION TO RELEASE INFORMATION

PLEASE PRINT CLEARLY

PATIENT'S NAME _____
LAST FIRST INITIAL

ADDRESS _____
STREET CITY STATE ZIP

PHONE (_____)_____ BIRTH DATE _____ SSN_____

Please List Medical Facility:

1.	2.	3.
NAME	NAME	NAME
ADDRESS	ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP	CITY STATE ZIP
PHONE NUMBER	PHONE NUMBER	PHONE NUMBER
FAX NUMBER	FAX NUMBER	FAX NUMBER

The type of information to be used or disclosed is as follows:

☐ X-RAYS (CD/Films)
☐ CT SCAN (CD/Films)
☐ MRI (CD/FILMS)
☐ RADIOLOGY REPORTS
☐ TREATMENT NOTES
☐ LAB WORK
☐ PRESCRIPTION (NAME/DOSAGE/FREQUENCY)
☐ ALLERGIES
☐ DRUG ALLERGIES
☐ HEMOGLOBIN A1C LAB WORK
☐ NECK (CERVICAL SPINE)
☐ MID-BACK (THORACIC SPINE)
☐ LOW BACK (LUMBAR SPINE)
☐ Other_____
☐ OTHER_____
☐ OTHER REMARKS_____
_____

This information may be disclosed to and used by the following organization:

KYLE J. PANKONIN, D.C.
RED ROCK CHIROPRACTIC CENTER
202 MAIN STREET, PO BOX 517
LAMBERTON, MN 56152
PHONE: 507-752-7650
FAX: 507-752-7635

The reason for disclosure of this information is for the following reason:

☒ Continued Healthcare ☐ Personal ☐ Other _____

I understand I have a right to revoke this authorization at any time by presenting a written revocation to the medical record department. I understand the revocation will not apply to:

- Information already released in response to this authorization
- My insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event, or condition, this authorization will be in effect for one year from this date, for records generated as a result of services occurring on or prior to this date.

SIGNED _____ DATE_____
(IF NOT PATIENT, STATE RELATIONSHIP)