Red Rock Chiropractic Center

New Patient Form (Ages 0-4)

OFFICE USE ONLY
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:** _____
Home phone: (____)_____ - _____
Cell phone (mom): (____) _____ - _____
Cell phone (dad): (____) _____ - _____
Parent home email:_____
Best contact method: ☐ Home phone ☐Cell phone(mom) ☐Cell phone(dad) ☐Home email

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/word of mouth _____

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: _____

PATIENT PREFERENCES

In the event you need to have therapy for greater than 5 minutes, what is your favorite music to listen to for relaxing?
_____

PREVIOUS CHIROPRACTIC CARE

Have you seen a chiropractor before? ☐No ☐Yes
If yes, when was the last time you have seen one? _____
How many chiropractic visits have you had this year? _____

ADDITIONAL SERVICES

Please mark any services besides chiropractic adjustments you might be interested in receiving here: ☐Decompression ☐Hydromassage ☐Food sensitivity testing ☐Blood/lab testing for an in-depth health analysis ☐DOT physicals ☐Sports physicals ☐In-office rehab ☐Custom-made orthotics ☐Custom-made pillows ☐Drug/alcohol testing for your business ☐Functional medicine ☐MLS laser therapy ☐Weight loss ☐Exercise program ☐Pre-employment physicals

REASON FOR VISIT

What brings you to our office today? ☐Pain/symptom relief ☐Problem correction/prevention ☐Wellness/Overall health
In your own words, tell us what you are looking for help with: _____
_____

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 ☐Knee 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_____

Daily Living Effects

Please mark which activities are affected by the above conditions: ☐Lifting ☐Personal care (washing, dressing, etc.) ☐Sitting ☐Sleeping ☐Social life ☐Standing ☐Traveling ☐Walking ☐Exercise ☐Other _____

What is the most important thing you want to be able to do that you're currently not able to because of the condition(s)?

_____

Feet/Orthotic History

What is your shoe size AND width? _____ Do you currently wear orthotics? ☐No ☐Yes
If yes, from where did you get them? ☐Podiatrist ☐Chiropractor ☐Store (Walmart, etc.) ☐Other_____
How many days per week do you wear these kinds of shoes? Athletic _____ Dress _____ High Heels _____ Flats _____Industrial_____

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/Year	Surgery/Year	Surgery/Year	Surgery/Year

General Health History

STRESS

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

SLEEPING PATTERN

Please circle how many hours of sleep you get per night: 0 1 2 3 4 5 6 7 8 9 10 What is your sleep quality? ☐Excellent ☐Good ☐Fair ☐Poor
Please circle how many times your sleep is interrupted per night: 0 1 2 3 4 5 6 7 8 9 10

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.	

SOCIAL HISTORY

Caffeine used ☐Often ☐Occasionally ☐Never	**Wear seatbelt** ☐Always ☐Usually ☐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

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 video games? ____

PREGNANCY HISTORY: (If the child is adopted, answer to the best of your ability). Did you experience any of the following during your pregnancy:		
☐Accident or Infections	☐Hypertension (high blood pressure)	☐Smoking
☐Alcohol consumption and/or drug use	☐Pre-eclampsia	☐Toxemia
☐Breech position during pregnancy	☐Severe stress	☐Toxoplasmosis
☐Gestational diabetes	☐Severe viral infection during the first trimester	☐Other: _____

LABOR AND DELIVERY HISTORY: Did you and/or the child experience any of the following during labor/delivery:		
☐Birthing center	☐Emergency C-section	☐Placenta previa
☐Home birth	☐Fetal distress	☐Premature deliver (2+ weeks)
☐Hospital birth	☐Forceps or suction cups used	☐The child was a "blue baby"
☐Breech birth	☐Labor was induced	☐The delivery was rapid
☐Cord around the neck	☐Length of delivery _____	☐Other_____
☐Elective C-section	☐Long and/or difficult labor	

NEWBORN HISTORY Does or did the child experience any of the following as a newborn:		
☐Acid reflux	☐Difficulty latching/sucking	☐Poor sleeper
☐Breast fed	☐Distorted skull	☐Prolonged jaundice
☐Bottle fed	☐Formula fed	☐Required resuscitation/oxygen
☐Colic	☐Normal stool ☐Abnormal stools	☐Spits up excessively
☐Immunizations in hospital: If yes, please specify vaccine: _____		☐Weight at birth: _____ ☐Length at birth: _____

DEVELOPMENTAL HISTORY: Does or did your child have any of the following:		
☐Appears clumsy	☐Slow to walk alone	☐Slow responding to sound
☐Slow to sit up	☐At what age did your child start to walk unassisted:_____	☐Difficulty sitting still or paying attention
☐Difficulty with crawling (on all fours)	☐Difficulty or awkward with walking/running	☐Poor hand-eye coordination
☐ Did not crawl on all fours	☐ Difficulty using utensils	☐ Any other concerns not listed? _____
☐ Slow to stand	☐ Slow responding to visual stimuli	

MEDICAL HISTORY Please indicate if you have ever experienced or have been diagnosed as having any of the following:		
☐Abdominal pain	☐Double vision	☐Ovarian cysts
☐Acne	☐Drowning	☐Panic attacks
☐ADD/ADHD	☐Dyslexia	☐Paranoia
☐Allergy shots	☐Ear pain	☐Passive/aggressive behavior
☐Anemia	☐Easy bleeding	☐Peeling
☐Anger	☐Easy bruising	☐Pinched nerves
☐Animal bites	☐Eczema	☐Pinkeye
☐Anxiety disorder	☐Energy level problem	☐Pneumonia
☐Arthritis	☐Epilepsy	☐Poison ivy (oak, sumac)
☐Asthma	☐Eye injury	☐Poor coordination
☐Athlete's foot	☐Eyestrain	☐Poor posture
☐Autism/Autism spectrum disorder	☐Fainting	☐Post nasal drip
☐Bed wetting	☐Fatigue	☐Premenstrual syndrome
☐Bipolar disorder	☐Fevers/chills/sweats	☐Psoriasis
☐Blacking out	☐Foul odor of urine	☐Rashes
☐Blood in urine	☐Fractured jaw	☐Repetitive motion injury
☐Bloody stools	☐Frequent colds	☐Rheumatic fever
☐Bone pain	☐Frequent headaches	☐Ringing in ears
☐Bowel problems	☐Frequent urination	☐Scoliosis
☐Braces	☐Frostbite	☐Seizures/Convulsions

□Breathing problems	□Glasses/contacts	□Self-esteem issues
□Brittle nails	□Growing pains	□Sensitivity to light
□Broken bones	□Hay fever	□Serious fall(s) or repetitive falls
□Broken/knocked out teeth	□Head injury	□Severe headaches
□Bronchitis	□Hearing loss	□Shortness of breath
□Burning urination	□Heart disease	□Sinus problems
□Burns	□Heat exhaustion/heat stroke	□Skin ulcers
□Changes in moles	□Hiccups	□Sleep problems
□Chemical insensitivities	□Hyperventilation	□Sleeping disorders
□Chicken pox	□Hypoglycemia (low blood sugar)	□Snoring
□Choking	□Illnesses accompanied by a high fever	□Sore throat
□Chronic ear infections/earaches	□Ingrown toenails	□Spinning/balance
□Chronic fatigue	□Insect stings	□Sports injury
□Cold sores	□Insomnia	□Sprains/strains
□Concussion	□Itching	□Suicidal thoughts
□Constipation	□Jaw pain	□Sunburn
□Corns and calluses	□Joint pain	□Swelling
□Cough/Wheezing	□Joint stiffness	□Swollen glands
□Coughing of phlegm	□Lazy eye	□Tingling sensations
□Coughing up blood	□Lice	□Tourette's syndrome
□Cross eye	□Lower side pain	□Toxic shock syndrome
□Croup	□Meningitis	□Trouble sleeping through the night
□Cuts, scrapes, punctures	□Menstrual cramps	□Trouble with bladder control (enuresis)
□Deformity	□Menstrual problems	□Unconsciousness
□Dehydration	□Mood swings	□Unusual stress
□Depression	□Muscle ache	□Urinary infection
□Diarrhea	□Muscle weakness	□Vaginal yeast infection
□Difficulty urinating	□Neck or back problems	□Visual impairment
□Difficulty walking	□Neurological disorders	□Warts
□Digestive disorders	□Nosebleed	□Weakness
□Dislocations	□Numbness	□Weight loss/gain
□Dizziness	□Obsessive compulsive disorder	□Other: _____
□Number of doses of antibiotics taken in the past 6 months: _____	□Total number of doses of antibiotics taken during lifetime: _____	□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)