

# INTRODUCTION PATIENT CASE HISTORY

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## PATIENT INFORMATION

Name: (First MI Last) \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female Social Security #: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Method of Contact:  Text  Email  Phone - Home, Mobile, or Work  Other: \_\_\_\_\_

\*Referred By: (Name) \_\_\_\_\_

Family  Friend  Co-Worker  Doctor  Other: \_\_\_\_\_

Race & Ethnicity: (Choose up to 2)

- African American or Black
- American Indian or Alaskan Native
- Asian
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Decline

Preferred Language:

- English
- Spanish
- Other: \_\_\_\_\_
- Decline

## EMERGENCY CONTACT INFORMATION

Name: (First MI Last) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_

Doctor's Phone: \_\_\_\_\_

Relationship:

Child  Parent  Spouse  Other: \_\_\_\_\_

## FINANCIAL INFORMATION

Is today's visit the result of an accident?

No  Auto  Work  Other: \_\_\_\_\_

Will we be working with insurance?  No  Yes (Details)

Primary: \_\_\_\_\_ ID#: \_\_\_\_\_

Secondary: \_\_\_\_\_ ID#: \_\_\_\_\_

Where would you like statements sent?

Self  Other (Details below)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

*It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged*

Account No: \_\_\_\_\_

# HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS (Please describe)

Major Complaint: \_\_\_\_\_

Secondary Complaints: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

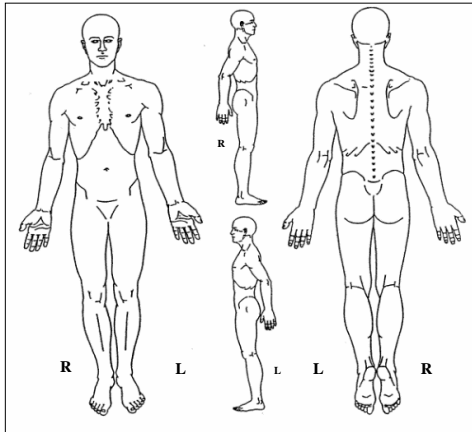
When did it start? \_\_\_/\_\_\_/\_\_\_ What happened? \_\_\_\_\_

Which daily activities are being affected by this condition? \_\_\_\_\_

\_\_\_\_\_

## MAJOR COMPLAINT

### Location of Symptoms and Radiation



P \_\_ Pain                      T \_\_ Tender  
 N \_\_ Numb                    H \_\_ Hypoesthesia  
 S \_\_ Spasm

### Grade Intensity/Severity:

- None (0/10)
- Mild (1-2/10)
- Mild-Moderate (2-4/10)
- Moderate (4-6/10)
- Moderate-Severe (6-8/10)
- Severe (8-10/10)

### Frequency:

- Off & On
- Constant

### Quality:

- Sharp
- Stabbing
- Burning
- Achy
- Dull
- Stiff & Sore
- Other: \_\_\_\_\_

### Does it radiate?

- No     Yes (Please indicate on drawing)

### Improves with:

- Ice
- Heat
- Movement
- Stretching
- OTC Medications: \_\_\_\_\_
- Other: \_\_\_\_\_

### Worsens with:

- Sitting
- Standing/Walking
- Lying Down/Sleeping
- Overuse/Lifting
- Other: \_\_\_\_\_

### Previous Treatment:

- None
- Chiropractor \_\_\_\_\_
- Medical Doctor \_\_\_\_\_
- Physical Therapy \_\_\_\_\_
- ER/Urgent Care \_\_\_\_\_
- Orthopedic \_\_\_\_\_
- Other: \_\_\_\_\_

### Previous Diagnostic Testing:

- None
- X-rays \_\_\_\_\_
- MRI \_\_\_\_\_
- CT \_\_\_\_\_
- Other: \_\_\_\_\_

### \*Women: Are you pregnant?

- No    Last Menstrual Period: \_\_\_/\_\_\_/\_\_\_
- Yes                      Due date: \_\_\_/\_\_\_/\_\_\_

### Present Illness Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Prescription Medications & Supplements:    None

Yes (List - Name, dosage, frequency) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Allergies to Medications:    No known drug allergies

Yes (List - Name and reaction) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# PAST, FAMILY, AND SOCIAL HISTORY

## PAST MEDICAL HISTORY

Have you **ever** had any of the following? (Please select all that apply and use comments to elaborate.)

### Illnesses:

- Asthma
- Autoimmune Disorder (Type) \_\_\_\_\_
- Blood Clots
- Cancer (Type) \_\_\_\_\_
- CVA/TIA (stroke)
- Diabetes
- Migraine Headaches
- Osteoporosis
- Other: \_\_\_\_\_

### Hospitalizations: (Non-surgical with Date)

\_\_\_\_\_

\_\_\_\_\_

### Surgeries: (If yes, provide type & surgery date)

- Cancer \_\_\_\_\_
- Orthopedic
  - Shoulder – R / L \_\_\_\_\_
  - Elbow/Forearm – R / L \_\_\_\_\_
  - Wrist/Hand – R / L \_\_\_\_\_
  - Hip – R / L \_\_\_\_\_
  - Knee – R / L \_\_\_\_\_
  - Ankle/Foot – R / L \_\_\_\_\_
- Spinal Surgery
  - Neck: \_\_\_\_\_
  - Back: \_\_\_\_\_
- Other: \_\_\_\_\_

### Medical History Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Injuries:

- Back Injury
- Broken Bones
- Head Injury
- Neck Injury
- Falls
- Other: \_\_\_\_\_

## FAMILY HISTORY (Please mark X to all that apply and use comments to elaborate.)

- Unknown     Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death (if Deceased)								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

### Family History Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## SOCIAL AND OCCUPATIONAL HISTORY

**Marital Status:**  Single  Married  Divorced  Other

**Children:**  None  1  2  3  4  Other: \_\_\_\_\_

**Student Status:**  Full Student  Part Student  Non-Student

**Highest level of Education:**  High School  College Grad.

Post Grad.  Other: \_\_\_\_\_

**Employed:**  No  Yes (Occupation) \_\_\_\_\_

**Dominant Hand:**  Right  Left  Ambidextrous

**Smoking/Tobacco Use:** If current smoker, amount = \_\_\_\_\_

- Every Day  Some Days  Former  Never

**Alcohol Use:**

- Every Day  Weekly  Occasionally  Never

**Caffeine Use:**

- Coffee  Tea  Energy Drinks  Soda  Never

**Exercise frequency:**

- Daily  3-4xs/week  2-3xs/week  Rarely  Never

**Social History Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

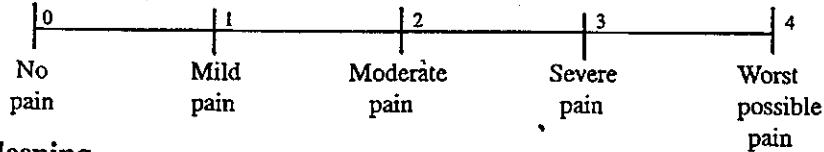


# Functional Rating Index

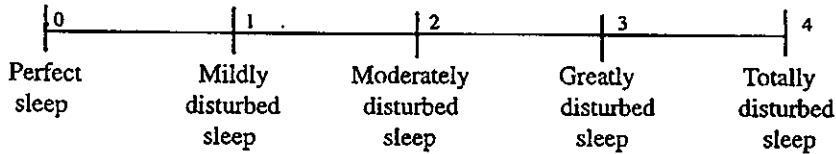
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

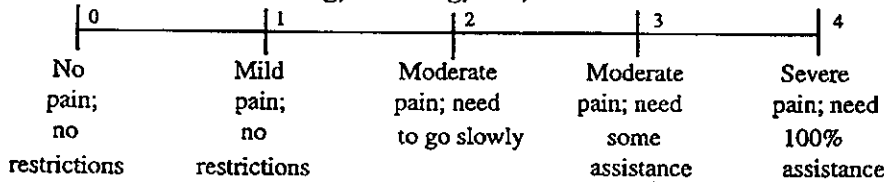
## 1. Pain Intensity



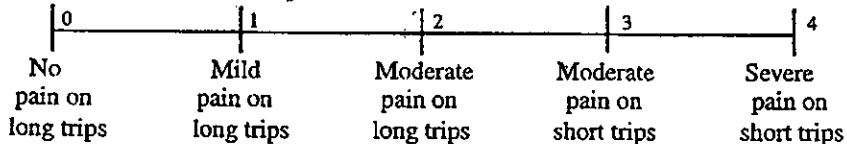
## 2. Sleeping



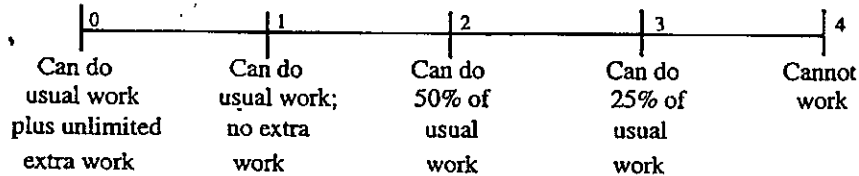
## 3. Personal Care (washing, dressing, etc.)



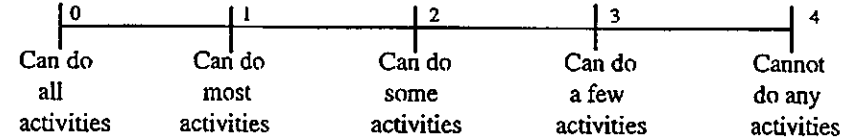
## 4. Travel (driving, etc.)



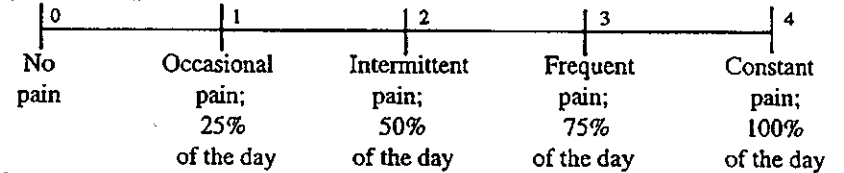
## 5. Work



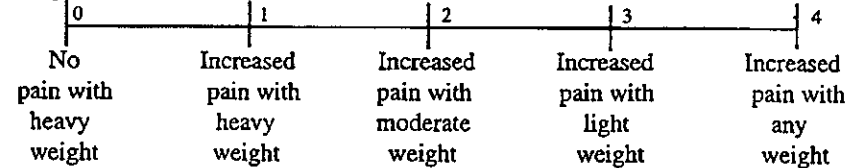
## 6. Recreation



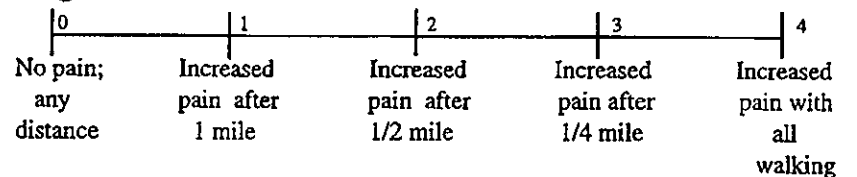
## 7. Frequency of pain



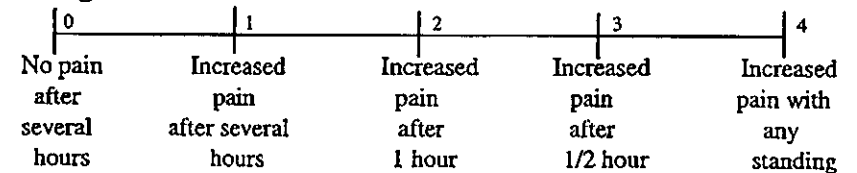
## 8. Lifting



## 9. Walking



## 10. Standing



Name \_\_\_\_\_ ID#/SS# \_\_\_\_\_ Plan ID \_\_\_\_\_ Total Score \_\_\_\_\_

PRINTED

Signature \_\_\_\_\_

Date \_\_\_\_\_

**HIPAA Notice of Privacy Practices**  
River Valley Family Chiropractic  
210 North Meridian Street Suite 1  
Belle Plaine, MN 56011

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

If you have any questions about the above notice, please contact our Privacy Officer, Dr. Steven A. Gansen, D.C. at (952) 873-4275.

**Our Obligations**

We are required by law to:

- Maintain the privacy of protected health information
- Give you the notice of your legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

**How We May Use and Disclose Health Information**

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practice's privacy officer.

**Treatment.** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

**Payment.** We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.

**Health Care Operations.** We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.

**Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services.** We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Research.** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.

**Special Situations**

**As required by law.** We will disclose Health Information when required to do so by international, federal, state, or

local law.

**To Avert a Serious Threat to Health or Safety.** We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.

**Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.

**Organ and Tissue Donation.** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.

**Military and Veterans.** If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

**Worker's Compensation.** We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

**Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6) in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

**Coroners, Medical Examiners, Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

**National Security and Intelligence Activities.** We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

**Protective Services and Intelligence Activities.** We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

**Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

### **Your Rights**

You have the following rights regarding Health Information we have about you:

**Right to Inspect and Copy.** You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

**Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

**Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. **We are not required to agree with your request.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Right to Request Confidential Communication.** You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

### **Changes to This Notice**

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

### **Complaints**

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

By Subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

---

Patient Signature

---

Date



**RIVER VALLEY**  
**FAMILY CHIROPRACTIC**

**DR. STEVEN GANSEN, D.C.**

210 North Meridian Street

Belle Plaine, MN 56011

(952) 873-4275

As a participating provider with BC/BS MN and its affiliates, Cigna, Health Partners, Medicare, Ucare, Medica, United Health Care and PreferredOne, we are to notify you of services that these insurance companies or any other insurance company may deem medically unnecessary or investigative:

<b>SERVICE</b>	<b>EST. PRICE</b>
<b>THERAPIES</b>	\$30
<b>EXAMINATIONS</b>	\$39.50
<b>X-RAYS</b>	
<b>WELLNESS VISITS</b>	\$45
<b>DURABLE MEDICAL EQUIPMENT</b>	
<b>KINESIO TAPING</b>	\$47
<b>ACUPUNCTURE</b>	\$20

I have been informed that these services may not be covered by my insurance company. This notification holds me financially responsible for these non-covered services.

SIGNATURE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

DATE \_\_\_\_\_



**RIVER VALLEY**  
**FAMILY CHIROPRACTIC**

**DR. STEVEN GANSEN, D.C.**  
210 North Meridian Street  
Belle Plaine, MN 56011  
(952) 873-4275

## CONSENT FOR THE TREATMENT OF A MINOR

Date: \_\_\_\_\_

I hereby authorize Dr. Gansen and whomever he may designate as assistants to administer examination and chiropractic care as deemed necessary to:

\_\_\_\_\_

*Minor Patient's Name*

\_\_\_\_\_

*Printed Name of Parent or Guardian*

\_\_\_\_\_

*Signature of Parent or Guardian*

\_\_\_\_\_

*Signed Date*

\_\_\_\_\_

*Witness*

\_\_\_\_\_

*Signed Date*

Parent Remarks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_