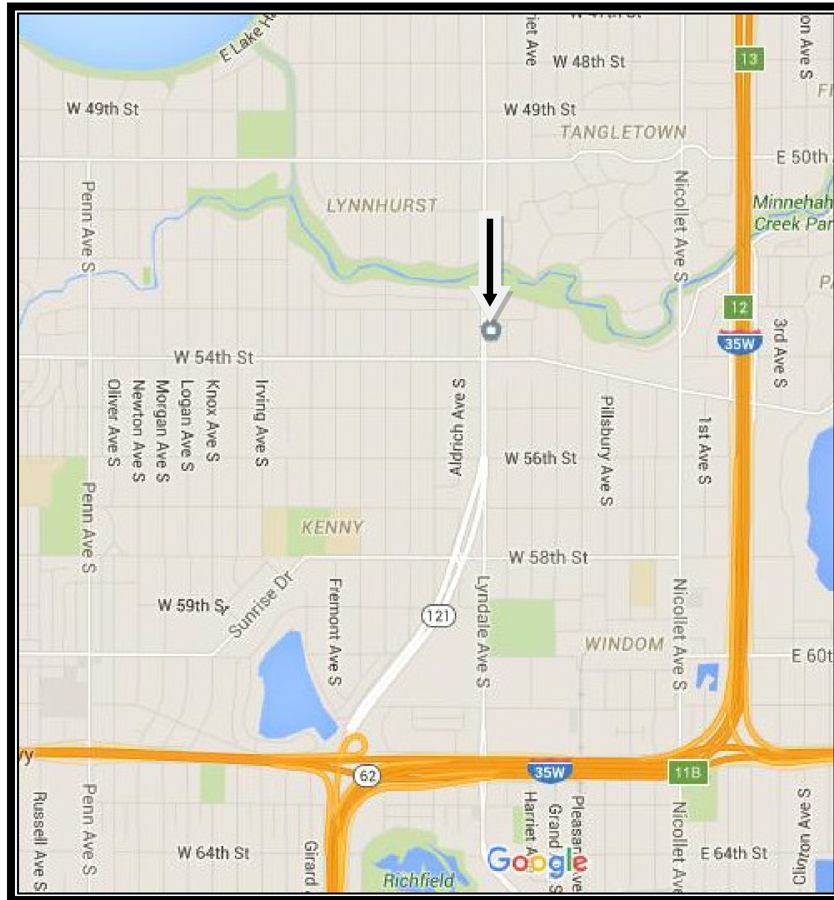
Nokomis Chiropractic & Wellness
Dr. Jonathan W. Olson & Dr. Matthew Amundgaard
5313 Lyndale Avenue South   Minneapolis, MN 55419
612-822-0149 www.NokomisChiropractic.com



Nokomis Chiropractic & Wellness is located, on Lyndale Avenue, between 53rd and 54th streets. We are in the same building as Prima and Subway just North of Kowalski's Market and South of the Washburn Library. To enter our office you will need to **park and enter from the back.**

If you are going South on Lyndale, turn left on 53rd Street and go approximately ½ block, (just past Mulberry's Cleaners) then turn right into the parking lot. Our office is located on the South end of the lot. When you enter the building we will be the first door on the left.

If you are going North on Lyndale, turn right on 54th Street and go one block to the light, which is Garfield. Turn left at Garfield and go to the 3rd driveway on your left…when you enter you will see our clinic directly in front of you.

We are on the main level and there is handicapped parking right outside the door.
If you need additional directions or assistance coming in from the parking lot,
please call us at 612-822-0149.

Meanwhile, we look forward to being of service.

PATIENT INFORMATION

ACCT#

Last Name ______________________ First Name ______________________ Middle Initial ________

Address ______________________ SS# ______________ Birth Date __________ Age ________

City ______________ State ______ Zip ______________ Male ☐ Female ☐ Marital Status: S M W D Separated

Occupation ______________________ Health Insurance ______________________

Employer ______________________ Insurance/Policy # ______________________

Home Phone # ______________ Work Phone # ______________ Cell Phone # ______________

Email Address ______________________ Emergency Contact ______________________

Spouse Name ______________________ Phone# ______________________

Occupation ______________________ Relationship ______________________

Employer ______________________ Referred by ______________________

Children (Name/Age) ____

CURRENT COMPLAINTS

Please list your major complaints	How long have you had this problem?	Is it getting better (B) worse (W) or same (S)	Is it constant (CS) or comes & goes CG?
1) ______________________	__________	B W S	CS CG
2) ______________________	__________	B W S	CS CG
3) ______________________	__________	B W S	CS CG

Did your injury occur ☐ While at work? ☐ Motor vehicle accident?

Is this condition ☐ NEW ☐ OLD Was it treated before ☐ YES ☐ NO

If treated before, what was done? ______________________

____

Names of Doctors ______________________

____

Medications you currently take ______________________

____

PAIN LOCATION & TYPE

Using the codes below, please mark on the drawing to indicate where your pain is and what you are feeling.

R L L R

- **Sharp** x x
- **Burning** + +
- **Dull Pain** √ √
- **Pins & Needles** ○ ○
- **Numb** ● ●

HEALTH HISTORY

From birth to present, please list by date and describe any car accidents, work-related, recreational, athletic or other injuries.

____

____

____

____

____

Have you ever been hospitalized? ☐ YES ☐ NO

List any Surgeries

______________________ ______________________

______________________ ______________________

HEALTH STATUS REVIEW

Please check all current and past conditions, even if they don't seem related to your complaint.

☐ Neck pain	☐ Carpal Tunnel	☐ Thyroid problems
☐ Mid back pain	☐ Frequent colds	☐ Heart problems
☐ Low back pain	☐ Ear Infections	☐ High/low blood Pressure
☐ Headaches	☐ Sinus Problems	☐ Prostate problems
☐ Migraine	☐ Asthma	☐ Impotence
☐ Numb arms/hands	☐ Allergies	☐ Dizziness
☐ Numb legs/feet	☐ Ulcers/Colitis	☐ Depression
☐ Arthritis	☐ Constipation	☐ Loss of sleep
☐ General stiffness	☐ Diarrhea	☐ Diabetes
☐ Shoulder problems	☐ Eczema/Shingles	☐ Cancer
☐ Knee problems	☐ Fatigue/Tired	☐ Substance abuse
☐ Other ______________________		

Women only: Do any of the following apply to you?

Pregnant?	☐ Yes	☐ No	Painful periods?	☐ Yes	☐ No
Nursing?	☐ Yes	☐ No	Irregular cycles?	☐ Yes	☐ No
Birth control?	☐ Yes	☐ No	Breast implants?	☐ Yes	☐ No

CHIROPRACTIC EXPERIENCE

Have you ever had Chiropractic care before? ☐ YES ☐ NO

NAME OF DOCTOR	DATE
______________________	__________
______________________	__________

Date of last spinal X-rays or other X-rays ______________________

HEALTH CARE GOALS

Describe how your current health complaints interfere with the different areas of your life: Work, Family, Relationships, Sports, Hobbies, House work, etc.

____

____

When was the last time you felt your best? ______________________

On a scale of 1-10 (1 is low, 10 is high)

Where would you rate your overall health, including physical, mental, nutritional, stress and energy? __________

What level of overall health would you like to have? __________

______________________________ __________

Patient Signature **Date**

Last Name________________________ First______________ Date___________ Account #_______________

Area of Complaint: ____
When did it start? ________________________ Is it getting: worse better same
How did it start? ____
How often? constant comes & go occasional other: ____________________
Describe the pain: sharp, dull, burning, throbbing, achy, numb, tight, pressure, tension, tingling, stiff, ROM
other: ____
Does the pain radiate?: yes no Where: ______________ Type of Pain: ______________
Frequency: constant comes & goes other: ______________________
What makes it worse?: ____
What makes it better?: ____
Who else have you seen?: ____
When it's at its worst on a scale of 1-10? __________ Average?: __________ Today? __________
Other: ____
____

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Who else have you seen?: ____
When it's at its worst on a scale of 1-10? __________ Average?: __________ Today? __________
Other: ____
____

FAMILY HISTORY

Family History: List any significant family health history by family member. (i.e. mother-high blood pressure)

Mother	Father	Sibling	Spouse	Children

Last Name: ________________________________ First Name ________________________ Account #:___________________

PATIENT HEALTH INFORMATION CONSENT FORM (HIPPA)

I agree to the policies and procedures of the Nokomis Chiropractic and Wellness Patient Health Information Consent Form, a copy of which has been made available for me at the front desk.

AUTHORIZATION FOR CARE/INFORMED CONSENT

I hereby authorize the Doctor(s) and staff of Nokomis Chiropractic and Wellness Center to treat my condition as deemed appropriate. I have been informed that all forms of health care, including chiropractic, have certain risks and possible side effects.

I understand that if the Doctor does accept my case, it does not guarantee or imply a guarantee of being able to cure or prevent any condition, illness or injury.

FINANCIAL/INSURANCE AGREEMENT

At Nokomis Chiropractic Center P.A., we accept most insurance plans and offer cash payments options. We will happily check your benefits and directly bill the insurance company for services covered per your policy with the following understanding.

I clearly understand insurance verification and authorization is not a guarantee of payment and that I am responsible for all services rendered including but not limited to: deductibles, co-payments, non-covered or denied services rendered, vitamins, supplements and durable goods. I authorize Nokomis Chiropractic Center P.A. to release my information to the insurance company in an effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance reimbursements. If care is suspended or terminated for any reason, any outstanding balance will become immediately due and payable.

Who should receive bills for payment on your account?

___Patient___Spouse___Parent___Worker's Comp___Auto Insurance___Medicare___Medicaid___Health Insurance

If insurance: Name of Primary Insured_____________________ Primary's Date of Birth____________Relationship_____________

Address of Primary Insured: ___Same or ____

______________________________ ______________ ______________________________ ______________

Patient Signature Date Parent or Guardian Date

X-RAY CONSENT

X-rays can be a necessary part of the overall evaluation. I consent to receive the x-rays recommended by the Doctor.

____________________________________ _________ __________________________________ __________

Patient Signature Date Parent or Guardian Authorizing Care Date

FEMALE PATIENTS ONLY Please check the appropriate statement:

_____I am not pregnant and consent to the x-rays recommended by the doctor.
_____I could be pregnant and would like to wait until I am sure before having x-rays taken.
_____I am pregnant.