TOTAL HEALTH
& HEALING CENTER

Dr. Thomas W. Miller, DC
Dr. Shanna C. Miller DC, CCN
Dr. Sarah Haggbloom, DC, ATC

PATIENT INFORMATION

Date: _____

Name: First_____Middle initial_____Last_____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail_____

Marital Status: M S W D Sex: M F

Date of birth: _____ Age _____

Employer _____ Occupation _____

Name of Spouse _____ Spouses date of birth_____

Spouses Employer _____ Occupation_____

Number of children: _____

Have you ever had chiropractic care before? _____

Where? _____

Who referred you to this office? _____

***Insurance (*for auto, work comp and personal injury claims*): Please present a copy of your insurance card or claim number, contact person's name, phone number, and address to send claims to the receptionist.**

Is this a work related injury? _____

Patient Health Questionnaire

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 4/19/99

Patient Name _____ **Date** _____

1. When did your symptoms start: _____ **Describe your symptoms and how they began:**

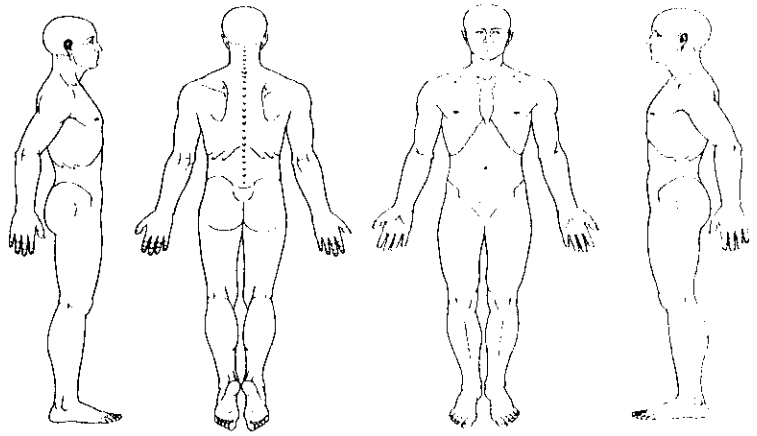
_____

_____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

10. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

11. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

12. What do you hope to get from your visit/treatment *(select all that apply):*

① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 1/20/99

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ] [ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Hormonal Replacement
○	○	Arthritis	○	○	Hepatitis	○	○	Pregnancy
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	
○	○	General Fatigue	○	○	Cancer	***Other Health Problems/Issues***		
○	○	Muscular Incoordination	○	○	Tumor	○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis	○	○	

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____

_____

List all the surgical procedures you have had and times you have been hospitalized:

_____

_____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

HEALTH HISTORY

Name _____ Date of Birth _____ Today's Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: Date began:

_____ _____

_____ _____

Date of last physical exam _____ Practitioner name and phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome _____

What types of therapy have you tried for this problem(s)

❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other _____

List current health problems for which you are being treated: _____

_____

Current medications (prescription or over-the-counter) _____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

_____

❑ Corrective lenses ❑ Dentures ❑ Hearing aid ❑ Medical devices/prosthetics/implants, describe _____

Recent changes in your ability to: ❑ see ❑ hear ❑ taste ❑ smell ❑ feel hot/cold sensations

❑ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Strong dislike for any one of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Do you: ❑ Prefer warmth (i.e., food, drinks, weather, etc.) ❑ Prefer cold (i.e., food, drinks, weather, etc.) ❑ No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the most energy or the least symptoms

❑ 7 a.m. - 9 a.m. ❑ 9 a.m. - 11 a.m. ❑ 11 a.m. - 1 p.m.
❑ 1 p.m. - 3 p.m. ❑ 3 p.m. - 5 p.m. ❑ 5 p.m. - 7 p.m.
❑ 7 p.m. - 9 p.m. ❑ 9 p.m. - 11 p.m. ❑ 11 p.m. - 1 a.m.
❑ 1 a.m. - 3 a.m. ❑ 3 a.m. - 5 a.m. ❑ 5 a.m. - 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

❑ 7 a.m. - 9 a.m. ❑ 9 a.m. - 11 a.m. ❑ 11 a.m. - 1 p.m.
❑ 1 p.m. - 3 p.m. ❑ 3 p.m. - 5 p.m. ❑ 5 p.m. - 7 p.m.
❑ 7 p.m. - 9 p.m. ❑ 9 p.m. - 11 p.m. ❑ 11 p.m. - 1 a.m.
❑ 1 a.m. - 3 a.m. ❑ 3 a.m. - 5 a.m. ❑ 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

❑ Debilitating fatigue	❑ Shortness of breath	❑ Insomnia	❑ Constipation	❑ Chronic pain/inflammation
❑ Depression	❑ Panic attacks	❑ Nausea	❑ Fecal incontinence	❑ Bleeding
❑ Disinterest in sex	❑ Headaches	❑ Vomiting	❑ Urinary incontinence	❑ Discharge
❑ Disinterest in eating	❑ Dizziness	❑ Diarrhea	❑ Low grade fever	❑ Itching/rash

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ Benign prostatic hyperplasia (BPH)
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Sexually transmitted disease

Other _____

Age of first period _____

Date of last gynecological exam ___

Mammogram ❑ + ❑ –

PAP ❑ + ❑ –

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C section _____

❑ Surgical menopause

❑ Menopause

Date of last menstrual cycle _____

Length of cycle ___ days

Interval of time between cycles ____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

- ❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

- ❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

- ❑ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine #cans/d _____

Other sources _____

❑ Water #glasses/d _____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk
- ❑ Run, jog, jump rope
- ❑ Weight lift
- ❑ Swim
- ❑ Box
- ❑ Yoga

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- ❑ Skip breakfast
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Graze (small frequent meals)
- ❑ Food rotation
- ❑ Eat constantly whether hungry or not
- ❑ Generally eat on the run
- ❑ Add salt to food

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs - teas
- ❑ Herbs - extracts
- ❑ Chinese herbs
- ❑ Ayurvedic herbs
- ❑ Homeopathy
- ❑ Bach flowers
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals

Other _____

Would you like to:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve your complexion
- ❑ Have stronger nails
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Do better on tests in school
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath
- ❑ Have agreeable body odor
- ❑ Have stronger teeth
- ❑ Get less colds and flus
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

MFT427 7/00 Rev 1/03

TOTAL HEALTH
& HEALING CENTER

NOTICE OF PRIVACY PRACTICES

Total Health and Healing Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide out patients with notice of your legal duties and privacy practices with respect to your protected health information.

There are certain times that we will disclose your healthcare information. These times include: for purposes of treatment, appointment reminders or missed appointment calls, payment, workers compensation, and health care operations. There are certain times where you can agree or object to disclosure of information. These times include: for purposes in the facility directory, persons involved in your care, and notifications to others.

Your rights:

1. You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Total Health & Healing Center is not required to agree to the restriction that you requested.
2. You have the right to your health information received or communicated through an alternative method or sent to an alternative location.
3. You have the right to inspect and copy your health information.
4. You have the right to request that your health information be amended. However, requests have been denied and an explanation will be provided along with measures as to how to disagree with your denial.
5. You have a right to receive an accounting of disclosures of your protected health information.
6. You have a right to a paper copy of this Notice at any time upon request.

Any changes made to this notice must be presented to you. Our privacy officer is Dr. Thomas Miller and complains and concerns can be presented to him at (763) 754-1482. This paper is a modified version of our HIPPA polices. A full copy can be obtained upon request and is always displayed at the front desk.

I have read, understand, and agree to the HIPPA polices at Total Health and Healing Center.

_____ _____ _____ Patient

Signature Date Witness

I am opting not to sign this agreement for the following reason(s):

_____

_____ _____ _____ Patient Signature

Date Witness

TOTAL HEALTH
& HEALING CENTER

Financial Policies and Guidelines

Total Health and Healing Center is a "fee for service" practice and Payment is due at the time of service. If you have insurance, we must emphasize that, as a wellness center, our relationship is with you, not your insurance company.

As a courtesy, we can provide our patients with a coded receipt to submit for reimbursement of any chiropractic coverage. Many of our services are considered preventative/ wellness care and therefore will not be covered by most insurance. We are under no obligation to provide Doctor's notes to your insurance company.

When you schedule a personalized appointment for your healthcare needs, that time is set aside for you. If you need to reschedule your appointment, we ask that you give us a minimum of 24 hours notice. We reserve the right to charge for any appointments missed without this notice. If you have a package, we will deduct that from your total.

Due to federal guidelines, we are unable to offer discount packages to patients submitting to Medicare. Many patients who have Medicare and are on a wellness program request that we not submit so they can take advantage of the package discounts.

*Supplement discounts applied to homeopathic remedies, medical foods, and nutritional supplements. The office visit package excludes the cost of orthotics, fitness bands, etc.

If at any time during the treatment period the package owner chooses to discontinue treatments, they will be reimbursed the remainder of their balance, minus all the discounts they have received to date. If a credit card was initially used to purchase the package a 3% processing fee will be applied to return. Notice must be given in writing and reimbursement will be made in one weeks' time in the form of a check.

Prices listed include 2% MN care tax.

I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS REGARDING THE FINANCIAL POLICIES AND GUIDELINES.

PRINT NAME _____

SIGNATURE _____

DATE _____