Date: ___/___/_____

New Practice Member Application

Name_____ Date of Birth____/_____/_____ Age_____ Male/Female
Address_____City_____State_____Zip_____
Cell _____Home _____Email_____
Occupation _____ Employer's Name _____
Single / Married / Divorced / Widowed Spouse's/Significant Other Name _____
Number of Children_____ Names, Ages, & Gender _____
Who may we thank for referring you?_____

Emergency Contact

Please list the name of someone we can call in case of emergency – if your primary emergency contact (i.e. spouse or parent/guardian) is already receiving care at True North we will attempt to call them first but would like a secondary in the event we are unable to reach them.

Name of emergency contact: _____
Relationship of contact to you: _____
Phone number(s) for contact: _____
Preferred Hospital: GUNDERSEN MAYO OTHER:_____

List the Main Health Concerns that Brought You into this Office

1) _____ 2) _____ 3) _____ 4) _____

Please Check Any Issues You Have Had in the Past or Currently Have

___ Neck Pain
___ Shoulder Pain
___ Arm Pain
___ Back Pain
___ Sciatica
___ Hip/Leg Pain
___ Knee Pain
___ Foot Pain
___ Numb/Tingling in extremities
___ Tight/Sore Muscles
___ Fibromyalgia
___ Poor Posture
___ Arthritis/Joint Pain

___ Scoliosis
___ Jaw/TMJ Pain
___ Headaches/Migraines
___ Frequent Colds/Ear Infections
___ Sinus Issues
___ Allergies
___ ADD/ADHD
___ Thyroid Issues
___ Loss of Energy
___ Sleep Problems
___ Anxiety/Nervousness
___ Depression
___ Double/Blurry Vision

___ Hearing Loss
___ Ringing in the Ears
___ Dizziness
___ Loss of Balance
___ Epilepsy/Seizures
___ Stroke
___ Tremors
___ Asthma
___ Sleep Apnea
___ Chest Pain
___ Difficulty Breathing
___ Heart Problems
___ Heart Attack

___ High/Low Blood Pressure
___ Nausea
___ Digestive Issues
___ GERD/Gastric Reflux
___ Diabetes
___ Kidney Problems
___ Bladder Problems
___ Bedwetting
___ Menstrual Problems
___ Prostate Problems
___ Sexual Dysfunction
___ Infertility
___ Cancer

Other conditions/diseases:
_____
_____

Name: _____ Date: ___/___/_____

Health History

List any surgical operations & years:

_____

_____

List any other injuries to your spine, minor or major, that the doctor should know about:

_____

Have you ever fractured or broken a bone? □ Yes □ No

If yes, please describe: _____

Other major traumas:

_____

_____

List all over-the-counter & prescription medications you are on and the reason for each:

_____

_____

_____

Notice of Privacy Practices Acknowledgement (HIPAA)

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____ Date: _____

Parent Guardian if under 18: _____ Date: _____

Image & Testimonial Release

On occasion we will ask to take photographs, videos, or other recordings at True North during regular business hours or at after hour events. We love to capture the health and healing that is happening here for further community education, and to spread hope to others who may be dealing with similar situations to yours. The media that we capture may be used for things such as, but not limited to, advertising, educational materials, or social media. By signing below, you authorize us to use your image, or that of your family members that visit the True North office or events. You agree that your statements were given freely without coercion or incentive. Any photos or stories can be reviewed for accuracy at any time and you may revoke the use of your image with 30 days written notice in writing.

Signature: _____ Date: _____

Parent Guardian if under 18: _____ Date: _____

Name: _____ Date: ___/___/_____

Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with Chiropractic care. The types of complications that have been reported secondary to Chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with Chiropractic care occurring at a rate between one instance per one million to one instance per two million cervical spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving Chiropractic care in the Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if Chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

- I understand and accept that there are risks associated with Chiropractic care and give consent to the examination that the Doctor deems necessary and the Chiropractic care, including spinal adjustments, as reported following my assessment.
- I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the practice member. It is customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I am financially responsible for charges not covered by this assignment.
- *If this Health Profile is for a Minor/Child:* I authorize Dr. Nicole Castellano, Dr. Christian Castellano, and any and all True North Chiropractic team members to perform diagnostic procedures, radiographic evaluations, render Chiropractic care and perform Chiropractic adjustments to my minor/child. As of this date, I have the legal right to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify True North Chiropractic.

Signature: _____ Date: _____
Parent Guardian if under 18: _____ Date: _____

X-Ray Authorization

As your healthcare provider, we are legally responsible for your Chiropractic records. If it is necessary to take x-rays, we must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. The fee for copying your x-rays on a disc is $15. This fee must be paid in advance. Digital x-rays on a CD will be available within 72 hours of pre-payment during regular practice hours. Please Note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The Doctors of True North Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice. By signing below, you are agreeing to the above terms and conditions.

Signature: _____ Date: _____
Parent Guardian if under 18: _____ Date: _____

FEMALE PRACTICE MEMBERS ONLY: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT** at the time the x-rays are taken at True North Chiropractic.

Signature: _____ Date: _____
Parent Guardian if under 18: _____ Date: _____