CENTER FOR NATURAL HEALTHCARE, PLLC

Providing Steps to Wholeness

Welcome to our clinic, we are here to serve you.

Our goal is to provide you with a totally natural approach to feeling your very best again.

Natural Medicine

• Chiropractic Treatment • Acupuncture • Detoxification • Lab & Food Sensitivity Testing • Nutritional Counseling • Laser • Personalized Health Coaching • Nutritional/Herbal Therapy • Hormone Testing/Treatment

Dr. Joseph H. Sevlie, D.C., FASA
1626 West 3rd Street • Red Wing, MN 55066 • 651-388-1211

PATIENT INFORMATION

Name:_____ Date: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Birthdate: _____ Age: _____ Sex: ☐ M - ☐ F Place of Employment: _____

Email:_____

Number of Children: _____ Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Emergency Contact: _____ Phone: _____

Referred by: _____

HEALTH INSURANCE

Who is responsible for your bill: (Check one) ☐ SELF ☐ SPOUSE ☐ PARENT

Type of Insurance: (Check one) ☐ HEALTH INSURANCE ☐ AUTO ☐ MEDICARE ☐ OTHER

Insurance ID#: _____ Insurance Company: _____

If your health insurance is being provided by your spouse/parent, please provide the following information:

Insured's Name:_____ Insured's Birthdate: _____

I authorize payment of medical benefits to Center for Natural HealthCare, PLLC for services. I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government benefits either to myself or to the above named party who accepts assignment.

Patient's Signature: _____ Date: _____

CURRENT HEALTH CONDITION

What do you want us to do for you? _____

_____

Other doctors you have seen for this condition: _____

_____

Date Condition Started: _____ (Check one) ☐ Job Related ☐ Auto Related ☐ Other

If disabled from work, give dates: _____

Drugs you take: (Check) ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Insulin ☐ Blood Pressure Medication

Other: _____

Are you pregnant? ☐ Yes ☐ No ☐ Maybe

PATIENT HEALTH HISTORY

Major Surgery/Operations: (Check) ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Broken Bones

Other: _____

Other Hospitalizations: _____

Major Accidents/Falls: _____

_____

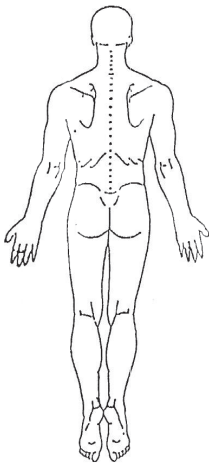
Treatment For Any Health Conditions This Last Year: _____

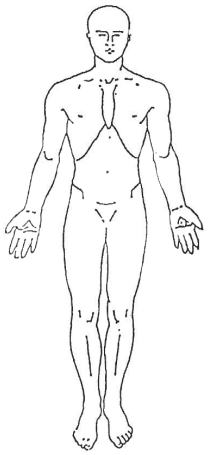
_____

Previous Chiropractic Care (Doctor's Name and Date of Last Visit): _____

PRESENTING PAIN SYMPTOMS

Please indicate the areas of pain you are experiencing today below.





	SHARP	BURNING	DULL PAIN	NUMB	NEEDLES
Neck	☐	☐	☐	☐	☐
Left Shoulder	☐	☐	☐	☐	☐
Right Shoulder	☐	☐	☐	☐	☐
Upper Back	☐	☐	☐	☐	☐
Mid Back	☐	☐	☐	☐	☐
Lower Back	☐	☐	☐	☐	☐
Left Elbow	☐	☐	☐	☐	☐
Right Elbow	☐	☐	☐	☐	☐
Left Hip	☐	☐	☐	☐	☐
Right Hip	☐	☐	☐	☐	☐
Left Knee	☐	☐	☐	☐	☐
Right Knee	☐	☐	☐	☐	☐
Left Ankle	☐	☐	☐	☐	☐
Right Ankle	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐

TREATMENT OPTIONS

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort ***(Initial Intensive)***. Others are interested in having the cause of the problem, as well as the symptoms, corrected and relieved ***(Rehabilitative)***. Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care ***(Comprehensive)***. Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of treatment desired so that we may be guided by your wishes whenever possible.

☐ **Initial Intensive** ☐ **Rehabilitative** ☐ **Comprehensive**

☐ **Check here if you want doctor to select the type of care appropriate for your condition.**

MEDICATION/SUPPLEMENTS SUMMARY

Over the Counter and Prescription Drugs, Vitamins, Minerals, Etc.

Date:	Drugs/Supplements Currently Using with Dosage and Purpose of Each

Note: Please bring in a copy of side effects of each drug - if you didn't receive one with your prescription, contact your pharmacist for a copy.

FAMILY HEALTH HISTORY

Please review the below listed diseases and conditions and indicate those that are current/past health problems of a family member.
Mark the space with the letter **"C"** for a **Current Problem**; use the letter **"P"** for a **Past Problem**. Leave spaces blank if they don't apply.

CONDITION	Father	Mother	Brother(s)	Sisters(s)	Children:
AGE(S)					
Allergies					
Anemia					
Arthritis					
Asthma-Hay Fever					
Autoimmune Disease					
Back Problems					
Cancer					
Chronic Fatigue					
Constipation					
COPD					
Diabetes					
Disc Problems					
Emotional Problems					
Emphysema					
Epilepsy					
Headaches					
Heart Problems					
High Blood Pressure					
Insomnia					
Kidney Problems					
Liver Problems					
Lung Problems					
Migraine					
Nervousness/Anxiety Attacks					
Scoliosis					
Sinus Problems					
Stomach Problems					
Stroke					
Thyroid Problems/Goiter					
Other:					

PAYMENT OPTIONS

Dear Patient,

We are a cash practice which means payment is due on the day of service. You have three options of payment at our office for services rendered. If you have insurance, your insurance forms will be electronically submitted, and reimbursement will come directly to you.
All laboratory testing is done on a cash basis only, so no insurance is submitted for lab work done.

Payment Options:

- Pre-payment plan: Pre-pay for 8 visits and receive the 9th visit at no charge.
- Cash or check payment
- Credit card payment. We accept Visa, Mastercard, American Express & Discover.

Informed Consent: I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment by cash, check or credit card. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature:_____ **Date:** _____

PERMISSION TO TREAT A MINOR

Parent or Guardian's Signature Authorizing Care: _____ **Date:** _____