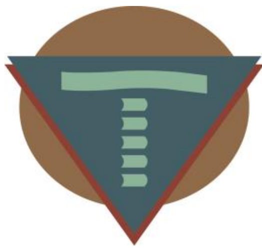


8441 Wayzata Blvd
Suite 120
Golden Valley, MN 55426
Phone: 763-546-6000
www.tchiro.com

Patient Information:

Last Name:			First Name:	MI:
Address:			Apt/Suite #:	
City:	St:	Zip	Date of Birth:	
Marital Status: Single Married Other	Sex: M / F		Social Sec. # (Optional):	
Home Phone:		Employer:		
Work Phone:		Occupation:		
Cell Phone:		Email Address:		
Name of Emergency Contact:				
Emergency Contact Phone #:			Relationship to Emergency Contact:	
How did you hear about us?				

Authorization – I hereby authorize Tierney Chiropractic (TC) to examine and care for my condition. TC has the right to release any medical or other information necessary to process any possible claims. I request payment of medical benefits from either a government or non-government source to TC. I authorize TC to initiate deemed complaints to the Insurance Commissioner on my behalf. **I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered**, and I understand that I will be charged at a 6% annual percentage rate on any non-contract insurance balances over 90 days. I further understand that I will be legally responsible for all collection costs involved with the collection of this account including all court costs, reasonable attorney fees and all other expenses incurred with collection, if I default on this agreement. In addition, if I issue a check that is returned by the bank for non-sufficient funds, I understand I will be charged $30.00 for each returned check. While TC will aide in the processing of my non-contract insurance claim, I understand that if my insurance does not pay within 60 days, my account will be adjusted to self-pay and due in full. I certify this information in true and correct to the best of my knowledge.

Signature   Date

Chief Complaint (your current presenting condition)

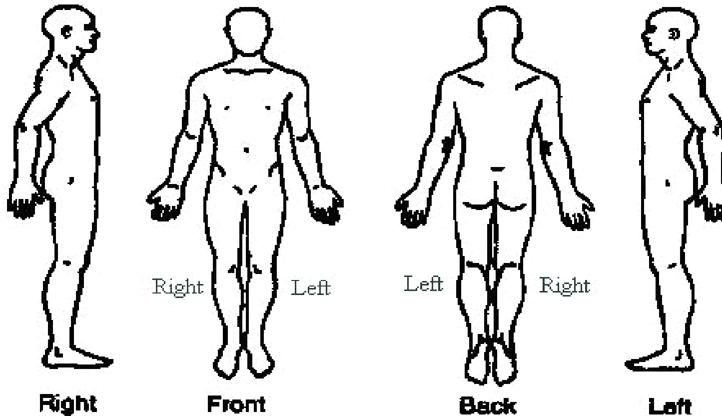
Describe your current injury or your current problem, if any:______________________________________

____

____

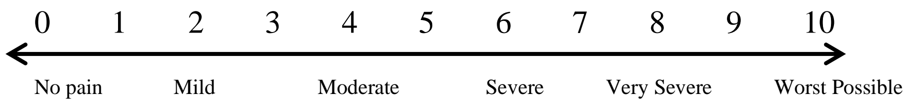
Please mark/draw your symptoms on the diagram:

Aching - XXX
Burning - ###
Numbness - ///
Pins/Needles - 000
Stabbing - ●●●



Doctor Use Only:

Rate your pain right now (mark as "O"); average pain level (mark as "X")



Is your condition due to a recent accident or a recent injury? ☐Yes ☐ No

If Yes, what type; ☐Worker's Comp ☐Motor Vehicle Accident ☐Sports Injury ☐Slip & Fall

(or other) ____

When did your complaints and/or symptoms begin?_______________________________________

What helps/alleviates this condition?____

What aggravates this condition?____

Have you sought alternative or medical care for this specific condition? ☐ Yes ☐ No If yes,

____

How do you want us to handle your current problem? (Check)

- ☐ Temporary/Relief Care – Treat the problem to reduce the symptom (with the problem likely to return)
- ☐ Stabilization Care – Treat the problem until the issue has stabilized and is improved
- ☐ Wellness Care - (Schedule Regular and on-going "tune-ups" for true preventative care)
- ☐ I would prefer to have Dr. Tierney discuss these options with me.

Review of Systems:

Please check any PRESENT or RECENT PAST (less than 3 months) symptoms you have experienced:

HEAD, FACE & JAW, PAIN / HEADACHE

- ☐ Side
- ☐ Front
- ☐ Base of Skull
- ☐ Top
- ☐ Band around Head
- ☐ Hat-type pressure
- ☐ Migraine
- ☐ Heavy head
- ☐ Throbbing from neck
- ☐ Affects Vision
- ☐ Produces Nausea
- ☐ Incapacitating

FACE:

- ☐ Pain
- ☐ Flushing
- ☐ Twitching

JAW:

- ☐ Pain
- ☐ Clicking

WORSE WHEN:

- ☐ Sleeping
- ☐ Eating

EYES, EARS, NOSE, THROAT & MOUTH:

- ☐ Pain
- ☐ Strain
- ☐ Red
- ☐ Light hurts
- ☐ Double vision
- ☐ Spots
- ☐ Glasses

EAR:

- ☐ Ache
- ☐ Ringing

NOSE:

- ☐ Bleeding

THROAT:

- ☐ Sore
- ☐ Painful
- ☐ Tightness
- ☐ Swallow Problems

NECK:

- ☐ Weakness
- ☐ Pain
- ☐ Stiffness
- ☐ Swelling
- ☐ Pain on motion
- ☐ Limited motion
- ☐ Throat muscles swollen/sore

WORSE:

- ☐ After sleeping
- ☐ During the day
- ☐ End of day

SHOULDER:

- ☐ Local pain
- ☐ Pain Down Arm
- ☐ Pain on motion
- ☐ Limited Pain
- ☐ Pain from Neck

WORSE:

- ☐ After sleeping
- ☐ During the day
- ☐ End of day

ARMS:

- ☐ Local Pain
- ☐ Radiates from Neck
- ☐ On movement
- ☐ Down arm-Sleeping
- ☐ Numbness
- ☐ Tingling
- ☐ Pins and needles
- ☐ Swelling
- ☐ Cold Hands
- ☐ Cannot Raise
- ☐ Loss of Grip Strength
- ☐ Down arm end of day

LOSS OF FEELING

- ☐ Elbow
- ☐ Wrist
- ☐ Fingers

MID-BACK:

- ☐ Weakness
- ☐ Pain
- ☐ Spasms
- ☐ Rib pain

WORSE:

- ☐ After sleeping
- ☐ During the day
- ☐ End of day

LOW-BACK:

- ☐ Weakness
- ☐ Pain
- ☐ Stiffness
- ☐ Swelling
- ☐ Pain on motion
- ☐ Limited motion

WORSE:

- ☐ After sleeping
- ☐ During the day
- ☐ End of day

PAIN IN:

- ☐ Hip
- ☐ Tailbone
- ☐ Groin

HIPS, KNEES, LEGS:

- ☐ Local Pain
- ☐ Radiating pain
- ☐ From back
- ☐ On movement
- ☐ Down leg
- ☐ Knee-Swelling
- ☐ Sciatica
- ☐ Numbness
- ☐ Tingling
- ☐ Loss of Feeling
- ☐ Ankle swelling
- ☐ Varicose Veins
- ☐ Cramps – Spasms
- ☐ Charlie horses

FEETS:

- ☐ Swelling
- ☐ Pain on walking
- ☐ Pain with back
- ☐ Cold
- ☐ Numbness

NERVES:

- ☐ Burning
- ☐ Numbness
- ☐ Tingling
- ☐ Pins and needles
- ☐ Tremor
- ☐ Nervous tension
- ☐ Dizziness
- ☐ Loss of Memory
- ☐ Poor equilibrium
- ☐ Loss of balance

SLEEP:

- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Poor due to pain
- ☐ Excessive amount

FATIGUE:

- ☐ Must rest during day
- ☐ Cannot get enough rest

INTERMITTENT:

- ☐ Tiredness
- ☐ Exhaustion
- ☐ Fatigue

CONSTANT:

- ☐ Tiredness
- ☐ Fatigue
- ☐ Exhaustion

WALKING CAUSES:

- ☐ Tiredness
- ☐ Fatigue
- ☐ Exhaustion

OTHER:

____

____

____

____

Doctor's Use Only

Past History/Lifestyle

Have you had any previous chiropractic, alternative or medical care for other condition(s)? ☐ Yes ☐ No
If yes, provide clinic name, care type and date range seen: ____

____

Do you have, had or been diagnosed as having:

Condition	Yes	No	Condition	Yes	No
Broken or Fractured Bones	☐ Yes	☐ No	Head Problems	☐ Yes	☐ No
Blood Pressure Problems	☐ Yes	☐ No	Heart Disease*	☐ Yes	☐ No
Cholesterol Problems	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Insomnia	☐ Yes	☐ No
Congenital Disease/disorder	☐ Yes	☐ No	Immune/Autoimmune*	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Loss of Bladder Control	☐ Yes	☐ No
Cortisone Injection*	☐ Yes	☐ No	Loss of Bowel Control	☐ Yes	☐ No
Coughing Blood	☐ Yes	☐ No	Lung Disease*	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Neuropathies	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No	Nervousness	☐ Yes	☐ No
Digestion Problems	☐ Yes	☐ No	Needing a Pacemaker	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No	Pacemaker*	☐ Yes	☐ No
Difficulty Breathing	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Ear/Hearing Problems	☐ Yes	☐ No	Ruptures	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No	Seizures/Convulsions	☐ Yes	☐ No
Epilepsy*	☐ Yes	☐ No	Speech Difficulty	☐ Yes	☐ No
Eye/Vision Problems	☐ Yes	☐ No	Strokes	☐ Yes	☐ No
Fainting History*	☐ Yes	☐ No	Tumors/Cancer History*	☐ Yes	☐ No
Gall Bladder Issues	☐ Yes	☐ No	Ulcers/Bleeding Disorder*	☐ Yes	☐ No

Other diagnosed conditions not listed:

LIFESTYLE

Do you use Tobacco?
☐ Yes ☐ No

Do you use Alcohol?
☐ Yes ☐ No

Do you use Caffeine?
☐ Yes ☐ No

Do you exercise regularly?
☐ Yes ☐ No

On average, how many fruits and vegetables do you consume Daily?

Fruits:

Vegetables:

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, describe____

____

Have you ever had any x-rays/MRI/radiographic films taken? ☐ Yes ☐ No
If yes, what? ____

Have you ever had surgery? ☐ Yes ☐ No

If yes, describe____

____

Are you currently taking any prescription medication or over-the-counter medication? ☐ Yes ☐ No

If yes, what?____

Are you currently taking any vitamin or mineral supplements? ☐ Yes ☐ No

If yes, what?____

Have you ever had or do you have any allergic reactions? ☐ Yes ☐ No If so, describe. ____________________

____

Do any immediate family members have (or had) a significant illness or disease? (i.e., Cancers, Diabetes, Hypertension, Migraines, High cholesterol, Strokes or other serious health conditions?) ☐ Yes ☐ No

If yes, what?____

Is there anything else? Are there additional complaints or seemingly unrelated conditions, not yet covered, that will be helpful in better understanding your case?

____

____

____

____

____

____

____

Initial ______ Upon signature of this document I am certifying that all the information provided above is true, correct and complete. If more information about my condition or illness becomes known, I will tell the doctor when possible so that it can be added to my record.

Informed Consent of Care

Chiropractic care, includes chiropractic adjustments that move bones via the doctor's hands or with the use of a mechanical device. It frequently create a "pop" or "click" sound/sensation in the area being treated) like all forms of health care, while providing considerable benefit to many, may also provide some level of risk. This level of risk is most often very minimal, yet in a rare number of cases, injury has been associated with chiropractic care.

Prior to receiving chiropractic care, a health history and physical examination will be completed. These procedures will be performed to assess your specific condition or concern. These procedures will assist the doctor in determining if chiropractic care is warranted, if we need to refer you to another clinic or if any further examinations or studies are needed.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system we cannot promise a cure for any symptom, condition or disease as a result of treatment. In addition, your health history helps 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 provided to you along with a care plan approach prior to beginning care. We strive for the best level of care and if the results are not acceptable, we will refer you to another provider whom we fell will assist your situation.

Possible risks associated with chiropractic care:

Soreness- Chiropractic adjustments as well as many physical therapy procedures pay produce post-treatment soreness. This is nearly always temporary. This is an accepted response accompanying care yet do inform your doctor about the soreness experienced.

Soft-Tissue Injury – Occasionally chiropractic treatment may overstretch soft tissue (most commonly effecting muscles and/or ligaments). This could result in a temporary increase of pain and the necessity of further treatments for resolution. There are no available statistics to quantity incidence of soft-tissue injuries as this occurs rarely.

Rib Injury – Manual adjusting to the thoracic spine, in rare cases, may cause rib injury or fracture. This occurs only in patients with weakened bones (osteoporosis). Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully and individualized to minimize such risk. These problems occur so rarely that there are no available statistics to quantify their incidence.

Physical Therapy Burns – Everyone's skin has different sensitivity to heat or ice generated by physical therapy applications and/or modalities. These modalities and/or devices may temporarily increase pain, possibly blister the skin from minor burns. These problems occur so rarely that there are no available statistics to quantify their incidence. As this is rare, if it happens to occur, you should report it to your doctor. Any home icing must have an insulating towel between your skin and the ice pack.

Stroke – A stroke occurs when a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is mixed or uncertain as to whether chiropractic adjustments are associated with stroke or not. The most recent evidence suggests that it is not (2008, 2015, 2016), although the same evidence suggests that the patient may be entering the chiropractic office for neck pain/headaches or other symptoms that may in fact be a spontaneous dissection of the vertebral artery. If we think this is happening, you will be immediately referred to emergency services.

As one of the rarest complications associated with chiropractic care, it is estimated that the incidence of stroke ranges between 1 per every 400,000 - 3,000,000 upper neck adjustments. The average chiropractor would need to be in practice for hundreds of years before they would statically be associated with a single patient stroke.

Disc Herniations: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc) will aggravate the problem and rarely surgery may become necessary for correction. These problems occur so rarely that there are no available statistics to quantity their incidence.

Other Problems – There could be other problems or complicates that arise from care other than those noted above. As these problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

I, (print name)____, understand and accept that there are risks associated with chiropractic care and I hereby give my informed consent to the examinations and treatments deemed necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment. The doctor will not be held responsible for any pre-existing medically diagnosed conditions. My name and other personal identifying information will be kept confidential following the rules of HIPPA.

____

Patient Signature Date

____

Parent or Guardian Signature Date

____

Interpreter Signature Date

Financial Policy and Missed Appointment Policy

Financial Policy

This **clinic is out-of-network** with all commercial medical insurance companies. You are personally responsible for the services received, which can be paid via cash, check and/or credit card payment types. **You may use HSA and/or Flex dollars to pay for chiropractic services** through your health insurance plan if this is a part of your service.

If desired, your **services may still be applied against your medical insurance deductible if you opt to self-submit** your claims to your carrier. As this clinic utilizes techniques, services, and protocols that most insurance carriers claim to be "experimental and investigational" (despite evidence since 1964), **your insurance carrier may still deny submitted services it deems as a "non-covered service" or "not medically necessary".** This may decrease possible deductible/ reimbursement amounts of self-submitted insurance-coverage of services received.

Fee Range of the Most Common Office Services (as of January 1, 2023, subject to change)

Services	Billed Fees	At "Time-of-Service" Fees
Initial Exam & Diagnosis	$175 - $296.00	$175 - $296 (New/last visit >36 mo.)
Established Pt Exam & Diagnosis	$101 - $228.00	$101 - $228
Spinal Adjustment(s)	$63 - $97	$63 - $97
Extremity Adjustment (s)	$38.35 - $76.70	$10 per region
Various Therapies	$25.13 - $53.58	$15 - $60
Functional Medicine Work-up	Non-covered service	$300 - $800
Functional Lab Test	Non-covered service	Varies $25 - $1,500.00
X-ray/Imaging	Refer out as necessary	

If you opt to submit your service to your insurance company, we will provide the necessary paperwork (super bill) that will allow for insurance acceptance for review. Non-covered services are billed directly to you. Any bill balances over 90 days old will be moved to our collection agency. You are responsible for any fees that are incurred by the collection agency. This includes required co-payments and deductible amounts, and certain limitations. We recommend, if you plan to self-submit that you call your insurance company before you visit to verify any possible benefits.

With chiropractic care, in certain instances, your health insurance carrier may not accept any of you treatment billing.

Missed Appointment Policy

In the event you are unable to make one of your appointments, please call our office in advance. We will reschedule your appointment as needed. **There may be a $70 charge for a same-day cancellation or appointment no-show.** If you, the patient, are more than 15 minutes late for you appointment, it is the doctor's discretion if there will be time to treat or if you will need to reschedule your appointment.

I acknowledge that I have read, understand and accept the above policies.

____ ____________________

Patient Signature (Parent/Guardian if under 18 years old) Date