

SYMMETRY



**CHIROPRACTIC &
PHYSICAL THERAPY**

www.symmetrychiropracticandphysicaltherapy.com

St Louis Park Clinic
5050 W 36th St Suite 100
St Louis Park MN 55416
Phone (952) 925-4085
Fax (952) 925-1394

Osseo Clinic
518 Central Ave
Osseo, MN 55369
Phone (763) 425-5525
Fax (952) 925-1394

Rosemount Clinic
14450 S Robert Trl #208
Rosemount, MN 55068
Phone (651) 423-2251
Fax (952) 925-1394

Duluth Clinic
2510 Maple Grove Rd #200
Duluth, MN 55811
Phone (218) 722-9300
Fax (952) 925-1394

Patient Health History

Name: _____

Height: _____

Weight: _____

Age: _____

Family Physician: _____

Please mark if you currently have/had any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> History Of Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Huntington's | <input type="checkbox"/> Asthma/Allergies |
| <input type="checkbox"/> Cauda Equina Syndrome | <input type="checkbox"/> Immunosuppression | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cerebral Vascular Accident | <input type="checkbox"/> Lupus | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Current Infection | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Diabetes Mellitus Type 1 | <input type="checkbox"/> Obesity | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Diabetes Mellitus Type 2 | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Lung Disease/Problems |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Heart Disease/Problems |
| <input type="checkbox"/> Fracture Or Suspected Fracture | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Circulation/Bleeding Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Epilepsy/Seizures |

Primary Concern/ Chief Complaint: _____

Is this condition getting worse?

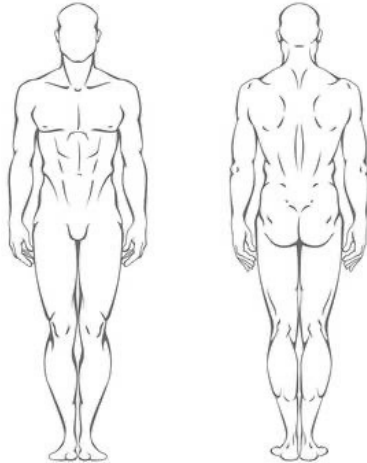
When did the symptoms appear?: _____

Yes No Same

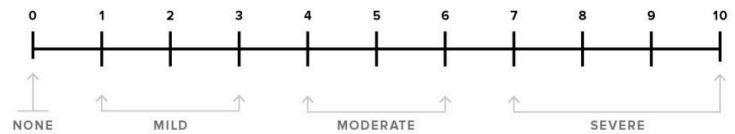
Are you currently working? Yes No

Mark on the diagram below the areas currently affected by your condition

X-Pain
O-Numbness
!!-Pins & Needles



Please indicate your pain level on the scale below



Please circle which goals you wish to achieve from attending therapy:

- | | | |
|--|--|--|
| <input type="checkbox"/> Regain Mobility & Strength | <input type="checkbox"/> Return to work | <input type="checkbox"/> Decrease pain |
| <input type="checkbox"/> Regain previous level of activity | <input type="checkbox"/> Maintain independent daily living | <input type="checkbox"/> Other: _____ |

Falls (please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> I have no falls | <input type="checkbox"/> I fall occasionally | <input type="checkbox"/> I have just started to lose my balance |
| <input type="checkbox"/> I fall frequently (more than twice in the last 6 months) | <input type="checkbox"/> Certain factors make me cautious (curbs, ice, stairs, and getting out of the tub) | |

What treatments have you already received for your condition?

- Surgery Physical Therapy Chiropractic Other

Please list past surgeries and dates:

1.	4.
2.	5.
3.	6.

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Consent to Treatment: I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination and treatment. I have received and/or read a copy of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Policy.

Financial Responsibility and Assignment of Benefits:

I understand and agree that, I am ultimately responsible for the balance of my account for any professional services rendered, durable medical equipment (DME) fit, or splints applied. If I choose to not pay any outstanding balance, I could be responsible for court costs and attorney's fees, and interest charges of 1.5% monthly or 18% annually on any outstanding balance not paid that is sent to small claims court. In the event of collection procedures, attorney fees and court costs are your responsibility. *I also understand that the delinquency fee with regards to collections will be equal to 50% of the principal amount owed.*

- Co- Payments:** Co-Payments are due at the time of service.
- Workers Compensation Claims:** We submit claims to workers compensation. However, if we received subsequent denials, you will be responsible of the total amount of charges.
- Self-Pay Policy:** Payment is due at the time of service.

Physical Therapy		Chiropractic		Dry Needling	
Initial Eval	\$125	Initial Eval	\$75	40 min Session	\$85
Session	\$100	Session	\$45	20 min Session	\$55
		Modalities	\$15		

- Auto Claims:** We submit claims to auto insurance. However, if benefits are exhausted or they pay you first you will be responsible of the total amount of charges.
- Cancellation/No Show Policy:** We require 24 hours notice for cancellations. After three (3) such instances a \$50 fee will be charged. It will be required to have a credit card on file in order to reschedule any future appointments. This fee is not covered by insurance
- Timely Filing:** It is your responsibility to provide ALL insurance cards within 1 week of your initial appointment. You will be responsible of the total amount of charges if it is not provided in a timely manner.

Release of Medical Records (optional)

I hereby authorize Symmetry Chiropractic and Physical Therapy to release confidential health information about me, by releasing a copy of my medical record or summary or narrative of my protected health information to the physician/ person/ facility/entity:

Send Information To:

Name/Office:

Phone:

Address:

Fax:

I certify that I have read this form and understand its contents.

Patient/Parent/Guardian Signature

Date

Printed Name

Relationship to Patient