1510 2nd Ave W Ste 202, Williston, ND 58801 | Ph. 701-572-0884
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PERSONAL INFORMATION

Date: ____________ First Name: __________________Middle: ______________Last: ___________________

Date of Birth: _________________________ SSN: _____________________ Sex: _____________________

Address: ___________________________ City: ______________ State: ___________ Zip: _______________

Home Phone: ___________________________ Cell Phone: _______________________________________

Email: ____ Marital Status: _________________________

Emergency Contact: ____________________________ Relationship: _______________________________

Emergency Phone: ___________________________________

How did you hear about our office?

□Family/Friend ___________________________ □Newspaper □Facebook □Google □Provider Talk

Occupation: ______________________________ Employer: _______________________________________

PAYMENT INFORMATION

Please initial indicating that you have read through and understand each statement:

_______Lindvig Family Chiropractic – A Wellness Way Affiliate does not bill insurance directly with the exceptions of Medicare, therefore all services are PATIENT PAY ONLY *at the time of service* unless prior payment plan arrangements have been discussed.

_______It is the patient’s responsibility to check insurance coverage and submit claims to the insurance company. These claims are called “Superbills” and may be requested.

By signing below, I agree to the financial policy described above:

____ _________________________________
Signature Date

REASON FOR VISIT

Please describe the reason for your visit today: ____

____

____

PERSONAL HEALTH INFORMATION

Chief Complaint(s): Please list your complaints in order of severity, number one being the worst.

Complaint	When did it start?	How often do you experience the problem?	Please rate the severity, 0-10, 10 being the worst.
1.			
2.			
3.			
4.			
5.			

Injury:

Are your symptoms the result of an injury? ◻ Yes ◻ No

If yes:

When did the injury occur? _________________________

Did you receive treatment for this injury? ◻ Yes ◻ No If yes, by whom or where? ____

Describe the injury: ____

____

Medications: Please list any medications you are currently taking or have recently taken and the reason for taking them.

Medication	Reason	How long have you been taking the medication?	Dosage
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Supplements: Please list any supplements you are currently taking or have recently taken and the reason for taking them.

Supplement	Reason	How long have you been taking the supplement?	Dosage
1.			
2.			
3.			
4.			
5.			

Allergies: Please list any allergies to medications, foods, or supplements, as well as the type of reaction.

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Lifestyle:

Diet: How would you describe your diet: □ Excellent □ Good □ Fair □ Poor

How often do you consume:

Processed/Packaged Foods: □ Daily □ Weekly □ Occasionally □ Rarely □ Never

Diet Food Products: □ Daily □ Weekly □ Occasionally □ Rarely □ Never

Fresh/Homemade Foods: □ Daily □ Weekly □ Occasionally □ Rarely □ Never

Soft Drinks: □ Daily □ Weekly □ Occasionally □ Rarely □ Never

Caffeine (Coffee or Energy Drinks): □ Daily □ Weekly □ Occasionally □ Rarely □ Never

How much water do you drink per day (per 8 oz glass): □ 1-2 glasses □ 3-4 glasses □ 5-6 glasses □ 7-8 glasses or more

Exercise: How often do you exercise? □ Daily □ Weekly □ Occasionally □ Rarely □ Never

How long do your sessions last? □ Less than 30 min □ 30-60 min □ 60+ min

What type of exercise are you doing? □ Walking □ Running □ Other cardio □ Weight lifting/Resistance training □ Yoga/Pilates

Other: ____

Sleep: Average number of hours of sleep: ____________ Do you have trouble falling asleep or staying asleep? □ Yes □ No

Do you have trouble getting out of bed in the morning? □ Yes □ No Do you feel rested after sleeping? □ Yes □ No

Do you snore? □ Yes □ No Do you use any kind of sleep aid? □ Yes □ No

Tobacco: Do you currently use tobacco? □ Yes □ No

If yes, how long? ______________________ How much? _______packs/day

What type? □ Cigarette □ Smokeless □ Pipe □ Cigars

Have you previously used tobacco? □ Yes □ No If yes, how long? ______________________ How much? _______packs/day

What type? □ Cigarette □ Smokeless □ Pipe □ Cigars

Are you exposed to secondhand smoke? □ Yes □ No

Alcohol: How often do you consume alcohol? □ Often □ Occasionally □ Rarely □ Never

Drinks per week: _____________________

Stress: Please rate your level of stress: □ Mild □ Moderate □ Severe

What do you believe is the source of your stress? ____

Is your stress affecting your health? □ Yes □ No Describe: ____

____

What do you do to manage your stress? ____

FEMALE ONLY:

Are you currently pregnant? □ Yes □ No If yes, how many weeks? ____

Check the box if yes and provide number:

□ Pregnancies_____ □ Miscarriage_____ □ Children_____ □ Abortion_____ □ Cesarean_____ □ Vaginal Delivery_____

□ Postpartum Depression_____ □ Pre-eclampsia_____ □ Gestational Diabetes_____

Menstrual History: Age At 1st Period ______ Menses Frequency _______________________ Length _________________________

Please mark any symptoms you currently experience or have experienced in the past:

□ Acne □ Abnormal hair growth □ Anxiety □ Irregular periods □ Absent periods □ Painful periods □ Clotting

□ PCOS □ Thinning hair □ Unexplained weight loss/gain □ Thyroid disorders □ Difficulty getting pregnant

□ Chronic fatigue □ Menopause (age)_____ □ Hysterectomy (age)_____

Birth control: □ Never □ Previously □ Currently Type (pill, IUD, etc): ____

Date of last menstrual period: ____

Health History

Have you ever had any of the following?

Illnesses			
Allergies	Yes	No	
Anemia	Yes	No	
Angina	Yes	No	
Arthritis	Yes	No	
Asthma	Yes	No	
Anxiety	Yes	No	
Bronchitis	Yes	No	
Cancer	Yes	No	
Chicken Pox	Yes	No	Age: _____
Crohn's Disease	Yes	No	
Diabetes	Yes	No	
Depression	Yes	No	
Dermatitis/Eczema	Yes	No	
Emphysema	Yes	No	
Epilepsy	Yes	No	
Fatigue	Yes	No	
Gallstones	Yes	No	
GERD	Yes	No	
Heart attack	Yes	No	
Heartburn	Yes	No	
Heart failure	Yes	No	
Hepatitis	Yes	No	

Illnesses			
High Blood Pressure	Yes	No	
Irritable bowel	Yes	No	
Kidney stones	Yes	No	
Measles	Yes	No	Age: _____
Mumps	Yes	No	Age: _____
Pneumonia	Yes	No	
Rheumatic fever	Yes	No	
Sinusitis	Yes	No	
Sleep Apnea	Yes	No	
Stroke	Yes	No	
Systemic Lupus	Yes	No	
Thyroid disease	Yes	No	
Ulcerative Colitis	Yes	No	

Other (describe): ___________________________________

Injuries		
Head Injury	Yes	No
Neck Injury	Yes	No
Back Injury	Yes	No
Fracture	Yes	No

Other (describe): ___________________________________

Please explain yes answers: ____

____

Diagnostic Studies:

			Date Performed
Neck X-rays	Yes	No	_____________
Back X-rays	Yes	No	_____________
Chest X-rays	Yes	No	_____________
MRI	Yes	No	_____________
CT scan of brain	Yes	No	_____________
CT scan of spine	Yes	No	_____________
Blood tests	Yes	No	_____________

Surgeries:

			Date Performed
Discectomy	Yes	No	_____________
Laminectomy	Yes	No	_____________
Spinal Fusion	Yes	No	_____________
Hysterectomy	Yes	No	_____________
Gallbladder	Yes	No	_____________
Appendix	Yes	No	_____________

Other (describe): ___________________________________

Please explain yes answers: ____

____

Hospitalizations:

Date(s)	Reason
1.	
2.	
3.	
4.	
5.	

I certify that I am the patient or legal guardian listed above. I have read/understand the information and certify it to be true and accurate to the best of my knowledge. I authorize Dr. Catrina Lindvig to examine and administer treatment as she deems necessary.

Signature:____ Date:________________________________