



# Back To Life Natural Health Center

## Holistic Natural Health Care

2960 Winnetka Ave. N. #110 Crystal, MN 55427

763-546-3736, Fax 763-546-3807

[www.backtolifehealth.com](http://www.backtolifehealth.com)

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## Welcome to Back To Life Natural Health Center!

We are happy that you have chosen Back To Life for your health care needs. Before your first visit, please fill out all of the enclosed forms. Take time to answer all the questions and be specific. This is very important in helping the doctor evaluate your current health status.

### Payment Policy

Please note that payment is due at the time of each visit. We regret that we are unable to make exceptions to this policy. However, we do accept Visa, MasterCard and Discover. If you wish to submit to insurance, we will give you a form to send in so that the insurance company can reimburse you. Our office will submit claims for auto accidents, and Worker's Compensation only. If you are covered under one of these please tell the receptionist.

### Cancellation Policy

Please let us know at least 24 hours in advance if you need to cancel your appointment. If sufficient notice is not provided, a missed appointment fee will be charged. This time has been reserved especially for you, and if you cannot use it, please give us the opportunity to offer someone else our care.

### What to Expect

The following paragraphs explain generally what you can expect in terms of treatment and cost. The treatment program does vary from person to person depending on the nature of the problem(s), so this is only an approximation of costs and frequency of treatment.

If you are coming in for Chiropractic treatment of muscular/skeletal problems only, the initial appointment will take about 30 minutes and will include an examination (usually \$45) and treatment (usually \$55-\$66). Additional treatments usually cost \$55-\$66 and vary in frequency depending on the severity of the problem (usually 1-2 times/week, initially).

If you are coming in for internal or other health concerns, the initial exam will take 60 minutes. The price is \$90. Follow up visits are \$2.50 per minute. Any phone consultations longer than 5 minutes will be billed on a per minute basis. If you schedule for the QFA (lab work), the cost is \$225. Please review the instructions for the fasting involved with the QFA carefully. During the initial exam and testing the doctor will discuss your treatment options and the costs involved. The doctor will often recommend specific supplements for you and these would involve additional charges.

We will be happy to answer any questions you may have. Thank you!



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### PATIENT INFORMATION

PLEASE PRINT CLEARLY

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone number \_\_\_\_\_ Work phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email address \_\_\_\_\_

Social Security number \_\_\_\_\_ Parents name (if pt. is a minor ) \_\_\_\_\_

Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Separated \_\_\_ Roommate \_\_\_ Ages of children \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's name \_\_\_\_\_ Employer \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

In case of emergency contact:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

### ALL FEES ARE PAYABLE ON THE DAY SERVICES ARE RENDERED

I understand I am financially responsible for all charges whether or not paid by insurance. I understand that Back To Life will prepare any necessary reports and forms to assist me in making collection from the insurance company.

I hereby authorize the Doctor and staff to test and treat my condition as they deem appropriate as long as I am consulted before any test or treatment is implemented.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### PERMISSION TO TREAT A MINOR (to be completed if the patient is under age 18)

I, (parent/ guardian ) \_\_\_\_\_ give Back To Life Natural Health Center permission to examine, test and treat (child's name) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

### INSURANCE INFORMATION (FILL OUT ONLY IF THIS VISIT IS DUE TO AN *AUTO ACCIDENT OR WORKMANS COMP. CLAIM*)

Insured's name \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance company name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Claim number \_\_\_\_\_ Policy number \_\_\_\_\_

If Workers Compensation, was an accident report filed? \_\_\_\_\_ Date \_\_\_\_\_

I authorize payment of medical benefits to Back To Life Natural Health Center for all services provided.

Signature \_\_\_\_\_ Date \_\_\_\_\_



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## Confidential Patient Case History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please Print**

What is your major complaint? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Other complaints: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had this or similar conditions in the past? \_\_\_\_\_

What activities aggravate the condition? \_\_\_\_\_

Is the condition getting worse? \_\_\_ Yes \_\_\_ No \_\_\_ Constant \_\_\_ Comes and goes

Is this condition interfering with your \_\_\_ Work \_\_\_ Sleep \_\_\_ Daily routine \_\_\_ Other \_\_\_\_\_

\*Please underline all of the following symptoms which you have now or have had previously. We want all the facts about your health before we treat you. Your health report is confidential and is treated as such by our staff.

### General Symptoms

784.4- Headache  
346.2- Allergic  
346.9- Migraine  
307.81- Tension  
780.6- Fever  
780.9- Chills  
780.8- Sweats  
780.2- Fainting  
780.4- Dizziness  
780.3- Convulsions  
780.52- Loss of sleep  
780.7- Fatigue  
799.2- Nervousness  
783- Loss of weight  
278.0- Obesity  
782- Numbness/pain  
in arms, hands or legs  
995.3- Allergies  
785.09- Wheezing  
729.2- Neuralgia

### E.E.N.T.

368.9- Failing vision  
367.1- Near sighted  
367.0- Far sighted  
378.9- Crossed eyes  
379.91- Eye pain  
389.9- Deafness  
388.70- Earache  
388.30- Ear noises  
388.6- Ear discharge  
784.7- Nose bleeds  
478.1- Nasal obstruction  
462- Sore throat  
784.49- Hoarseness  
477.9- Hay fever

493.9- Asthma  
521- Dental decay  
523.1- Gum trouble  
460- Frequent colds  
240.9- Enlarged thyroid  
463- Tonsillitis  
686.9- Sinus infection  
478.1- Nasal drainage  
785.6- Enlarged glands

### Skin

782.1- Skin eruptions  
696.1- Psoriasis  
692.9- Eczema  
698.8- Itching  
287.8- Bruises easily  
701.1- Dryness  
454.9- Varicose veins  
782- Sensitive skin  
708.9- Hives or allergy

### Respiratory

786.2- Chronic cough  
933.1- Spitting up phlegm  
786.3- Spitting up blood  
788.5- Chest pain  
786.09- Difficult breathing

### Cardiovascular

785- Rapid heart beat  
427.89- Slow heart beat  
401.9- High blood pressure  
458.9- Low blood pressure  
786.51- Pain over heart  
438- Previous heart stroke  
440.9- Hardening of arteries  
719.07- Swelling of ankles

459.9- Poor circulation  
436- Paralytic stroke

### Muscle & Joint Symptoms

716.9- Arthritis  
847- Stiff Neck  
722.10- Back ache  
719- Swollen Joints  
781- Tremors  
719.4- Painful joints  
724.79- Painful tailbone  
729.5- Foot trouble  
724.5- Pain between  
shoulders  
553.9- Hernia  
737.3- Spinal Curvature  
737.3- Faulty posture  
728.85- Muscle spasms  
724.8- Back spasms  
722.10- Sciatica

### Genito-urinary Symptoms

788.3- Frequent urination  
788.1 Painful urination  
599.7- Blood in urine  
599- Pus in urine  
592- Kidney infection or  
stone  
788.3- Bed wetting  
788.1- Inability to control  
urine  
601.9- Prostate trouble

### Gastro-intestinal Symptoms

783- Poor appetite  
536.8- Difficult digestion  
994.2- Excessive hunger  
787.3- Belching or gas  
787- Nausea  
787- Vomiting  
578- Vomiting blood  
536.8- Pain over Stomach  
787.3- Distention of  
abdomen  
564- Constipation  
558.9- Diarrhea  
789-Colon trouble  
455.6- Hemorrhoids  
785.1 Liver trouble  
575.9- Gallbladder trouble  
782.4- Jaundice  
558.9 Colitis

### For Women Only

625.3- Painful menstrual  
periods  
626.2- Excessive flow  
627.2- Hot flashes  
626.4- Irregular cycle  
625.3- Cramps/backache  
634.9- Miscarriage  
623.5- Vaginal discharge  
611.79- Congested breast  
611.72- Lumps in breast  
627.2- Menopausal symptoms

Have you ever had previous chiropractic care? \_\_\_\_\_ If yes, date of last care \_\_\_\_\_

**(Please Complete Reverse Side)**

**Medical Attention for Chief Complaint:**

Name and address of doctor \_\_\_\_\_  
 When attended \_\_\_\_\_ How long \_\_\_\_\_ Hospitalization \_\_\_\_\_  
 Examination and x-rays made \_\_\_\_\_  
 Diagnosis \_\_\_\_\_  
 Type and duration of treatment \_\_\_\_\_  
 Results of treatment \_\_\_ Good \_\_\_ Fair \_\_\_ Poor \_\_\_\_\_

**Previous Chiropractic History:**

Name and address of doctor \_\_\_\_\_  
 What were you treated for \_\_\_\_\_  
 Examinations and x-rays made \_\_\_\_\_  
 Cause of problem as explained by doctor \_\_\_\_\_  
 Treatment type & duration \_\_\_\_\_  
 Results: \_\_\_good \_\_\_fair \_\_\_poor \_\_\_\_\_

List surgical operations and years: \_\_\_\_\_  
 Drugs you now take: \_\_\_Blood pressure \_\_\_ Cholesterol \_\_\_ Pain killers \_\_\_ Muscle relaxants \_\_\_ Tranquilizers  
 \_\_\_ Insulin \_\_\_ Birth control \_\_\_ "Pep" pills \_\_\_ Allergy \_\_\_ others \_\_\_\_\_  
 Have you been in an auto accident? \_\_\_Past year \_\_\_ Past 5 years \_\_\_ over 5 years \_\_\_ Never  
 Describe \_\_\_\_\_  
 Have you had any other personal injury or accident \_\_\_ Past year \_\_\_ Past 5 years \_\_\_ Over 5 years \_\_\_ Never  
 Describe \_\_\_\_\_  
 Were you ever knocked unconscious or stunned? \_\_\_ No \_\_\_ Yes When and how \_\_\_\_\_

**FAMILY HEALTH INFORMATION:** (Many health problems are hereditary; thus information about your family members will give us a better picture of your total health picture)

Relation	Name	Age	Present Symptoms	Previous Serious Illnesses
Mother				
Father				
Sisters				
Brothers				
Children				
Spouse				

HAVE YOU EVER:	YES	NO	DESCRIBE BRIEFLY
Used a cane, crutch or other support?	___	___	_____
Been treated for a spine or nerve disorder?	___	___	_____
Had a fractured bone?	___	___	_____
Been hospitalized for other than surgery?	___	___	_____
Been diagnosed as having Hepatitis?	___	___	_____
Been diagnosed as having HIV or AIDS?	___	___	_____
Been diagnosed as having Mumps?	___	___	_____
Been diagnosed as having Measles?	___	___	_____
Been diagnosed as having Chicken Pox?	___	___	_____

**DO YOU:**

Currently take any vitamins or supplements?	___	___	_____
Think you may need vitamins or supplements?	___	___	_____
Have an allergy to any drug?	___	___	_____

HABITS:	HEAVY	MODERATE	LIGHT	NONE	LIST ALL CONDITIONS FOR WHICH YOU HAVE BEEN TREATED IN THE LAST TEN YEARS:
Alcohol	_____	_____	_____	_____	_____
Coffee	_____	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____	_____
Drugs	_____	_____	_____	_____	_____
Exercise	_____	_____	_____	_____	_____
Sleep	_____	_____	_____	_____	_____
Appetite	_____	_____	_____	_____	_____

\_\_\_\_\_  
 Signature of patient

(NORTH)

HWY 694/94

Rockford Rd

42<sup>nd</sup> Ave

HWY 169

HWY 100

36<sup>th</sup> Ave

Back To Life Natural Health  
2960 Winnetka Ave N #110  
(763) 546-3736



30<sup>th</sup> Ave

Medicine Lake Rd

Winnetka Ave N

HWY 55

HWY 394