Soma Chiro & Functional Medicine
2345 Rice Street Suite 155
Roseville, MN 55113

Phone: 651-528-7978
Fax: 651-528-7941
Email: info@somachiromn.com

New Patient Intake Form

Personal Information

First Name _____ Last Name _____ Prefix _____
Email Address _____ Phone Number: _____ Cell/Home/Work
Street Address _____ City: _____ State: ____ Zip: _____
Date of Birth _____ Gender _____ Legal Gender _____
Guardian (if minor) _____
Emergency Contact & Relationship _____
Emergency Contact Number_____
Family Doctor Name _____ Family Doctor Number _____
Referred By _____
Occupation _____ Employer _____
How Did You Hear About Us? _____

Primary Language Spoken _____
Marital Status _____ Spouse Name _____ Number of Children _____

Is This a Personal Injury/Worker's Comp Claim? Yes/No
If Yes, Who is the Responsible Party? _____
Do You Have Health Insurance? Yes/No
If Yes, What is Your Health Insurance Company? _____
Group Number/ID Number _____

Current Health Condition

Reason for visit:
_____
_____

When and how did your problem begin?
_____
_____

Have you received care for this problem? If yes, please explain.
_____
_____

What makes the problem better and/or worse?
_____
_____

Is the condition getting worse/ improving/ same? _____
Is the condition intermittent (on and off)/ constant/ unsure? _____

Describe the pain: (circle all that applies)
Aching/Dull/Deep/Sharp/Burning/Throbbing/Numb/Tingling/Other

Does the pain travel to: (circle all the applies)
Shoulders/arms/fingers/legs/feet/toes/none

Rate your **current** pain level: (0=no pain, 10=emergency room pain)
0 1 2 3 4 5 6 7 8 9 10

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Rate your **average** pain level: (0=no pain, 10=emergency room pain)
0 1 2 3 4 5 6 7 8 9 10

For Women Only:
Are you currently pregnant or suspect you could be pregnant? Yes/No/Unsure
If yes, expected due date? _____ Are you currently nursing? _____

Your Health Goals

Describe your health goals:
_____
_____

How would you rate your overall health currently? Poor/Fair/Good/Excellent/Unsure

Chiropractic History

What would you like to gain from chiropractic care?
Resolve existing condition _____ Overall wellness _____Both _____

Have you ever visited a chiropractor before? Yes/No

If yes, for what reason did you visit a chiropractor, what treatments were used, and what was the outcome of the treatments, and what did you like best/least about the treatments?
_____
_____
_____

Personal and Family Health History

Indicate if YOU or any IMMEDIATE family members have any of the following conditions:

Rheumatoid Arthritis ____ Diabetes ____ Lupus ____ Heart Disease ____
High Blood Pressure ____ Stroke ____ Cancer ____ Migraines ____

If you selected yes to any of the previous conditions, please specify who has/had the condition:
_____
_____

For each of the conditions listed, please check/circle if YOU have had the condition in the past or currently:

Headaches ____ Neck Pain ____ Upper Back Pain ____ Mid Back Pain ____
Low Back Pain ____ Shoulder Pain ____ Arm Pain ____ Wrist Pain ____ Hand Pain ____ Upper Leg Pain ____
Hip Pain ____ Knee Pain ____ Ankle/Foot Pain ____ Jaw Pain ____ Joint Swelling ____ Arthritis ____
Rheumatoid Arthritis ____ General Fatigue ____ Vision Problems ____ Ringing in the Ears ____ Memory Problem ____ Broken Bones ____ Pacemaker ____ Dizziness ____ High Blood Pressure ____ Heart Attack/Disease ____ Chest Pain ____ Stroke ____ Angina ____ Kidney Stones ____ Kidney Disorders ____
Loss of Bladder Control ____ Painful Urination ____ Bladder Infection ____
Prostate Problems (men only) ____ Abnormal Weight Change ____ Loss of Appetite ____
Abdominal Pain ____ Ulcer ____ Hepatitis ____ Tumor ____ Gall Bladder Problems ____

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Sensitivity to Light ____ Cold Hands/Feet ____ Liver Disease ____ Thyroid Problems _____ Asthma ____ Sinus Problems ____ Diabetes ____ Excessive Thirst ____ Frequent Urination ____ Tobacco Use ____ Drug Dependence ____ Alcohol Dependence ____ Allergies ____ Depression ____ Anxiety ____ Lupus (SLE) ____ Epilepsy ____ Dermatitis/Eczema/Rash ____ Concussion ____ Hormonal Replacement ____ Birth Control Pills ____ Pregnancy ____ Cancer ____ Muscular Incoordination ____ Loss of Balance ____ Loss of Concentration ____ Anemia ____ Osteoporosis ____ Other _____

Traumas: Physical Injury History

Have you ever had any significant falls, surgeries, accidents, or injuries? Yes/No
If yes, please explain:
_____
_____

Have you ever been hospitalized? Yes/No
If yes, please explain:
_____
_____

Have you had any notable childhood injuries? Yes/No
If yes, please explain:
_____
_____

Have you participated in youth or college sports? Yes/No
If yes, please explain:
_____
_____

Have you been involved in any car accidents? Yes/No
If yes, please explain and describe:
_____
_____

Lifestyle History

How much exercise do you perform:
1-2x/week ____ 3-5x/week ____ Daily ____ Seldom ____ Never ____

What types of exercises do you usually perform?
_____
_____

How do you normally sleep?
Back ____ Side ____ Stomach ____ Other ____

Do you usually wake up: (please check all the applies)
Refreshed ____ Tired ____ Stiff ____ Other ____

Do you commute to work? Yes/No
How many minutes per day do you commute to work? _____
How many hours per day do you typically spend sitting (work included)? _____

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Toxins: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each of the following: (1=never, 5=high)

Alcohol:	1 2 3 4 5
Water:	1 2 3 4 5
Sugar:	1 2 3 4 5
Dairy:	1 2 3 4 5
Gluten:	1 2 3 4 5
Caffeine:	1 2 3 4 5
Processed Foods:	1 2 3 4 5
Sweeteners:	1 2 3 4 5
Sugary Drinks:	1 2 3 4 5
Tobacco:	1 2 3 4 5
Recreational Drugs:	1 2 3 4 5
Fast Food:	1 2 3 4 5

Please list any allergies:

_____
_____

Please list any drugs/medications/herbs/vitamins/supplements/other that you are taking and what you are taking them for?

_____
_____
_____
_____

Thoughts: Emotional Stress

Please rate your STRESS for each: (1=none, 5=high)

Home:	1 2 3 4 5
Work:	1 2 3 4 5
Life:	1 2 3 4 5
Financial:	1 2 3 4 5
Health:	1 2 3 4 5
Family:	1 2 3 4 5
Other:	1 2 3 4 5

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, AND FINANCIAL RESPONSIBILITY
Soma Chiro & Functional Medicine

Name of Patient: _____ Date of Birth: _____

I hereby authorize Soma Chiro LLC dba Soma Chiro & Functional Medicine, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to the following:

a. Any person or entity responsible for payment for the medical services rendered to me at the Facility, including third party payors, self-insurers, worker's compensation carriers and government agencies or any person or entity acting as the agent or contractor of such party responsible for payment, in connection with obtaining payment for the medical services rendered to me at the Hospital by employees of the Facility or any person providing services at the Facility.
b. Federal, State or other governmental or quasi-governmental agencies or such other parties required by law for reporting purposes or for purposes of determining eligibility in government sponsored benefit programs.
c. Any person or entity participating in quality studies, utilization review or similar studies of the care rendered by the Facility and /or its physicians.
d. Any health professionals involved in my care for the purpose of facilitating the continuity of my medical care.
e. To persons authorized by the Facility in connection with the performance of supervised research in compliance with the rules and procedures of the Facility. I also understand that an authorized researcher may contact me at some future date.

I acknowledge that the above authorization has no expiration date and is valid to authorize the release of medical records and billing information at any time a valid request is received.

This includes information relative to alcohol abuse, drug abuse, psychological or psychiatric conditions and Acquired Immune Deficiency Syndrome (AIDS).

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to Soma Chiro LLC, d.b.a. Soma Chiro & Functional Medicine, separately from other Facility or professional bills. I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

FINANCIAL RESPONSIBILITY: In consideration of services rendered or to be rendered to the patient designated herein at my request for this occasion of service, I guarantee and agree to pay charges for those services rendered including any amount not paid in my insurance plan, Medicare, health service plan or health maintenance organization. Members of health maintenance organizations (and preferred provider organizations) are generally required to comply with certain policies and procedures requiring use of participating providers and compliance with plan requirements for primary referral, emergency admission, pre-certification and utilization review. These are conditions to payment of benefits by the health maintenance organizations (and preferred provider organizations). Soma Chiro LLC, d.b.a. Soma Chiro & Functional Medicine, may not participate with your health care coverage plan and their charges may not be covered.
By signing the financial responsibility statement, the patient and guarantor(s) acknowledge and agree they are responsible for payment of billed charges rendered in any case in which payment may be denied by the health maintenance organization (or preferred provider organization) because of a failure to comply with such coverage requirements or for any other reason.

A copy of this form shall have the same force and effect as the original.

I acknowledge that I have read and understand its contents fully. The undersigned is the patient, the patient's legal representative or is authorized by the patient to execute this form and accepts its terms.

_____ _____
(Signature of patient, parent or legal guardian of patient) (Date signed)

_____ _____
(Witness) (Date signed)

Chiropractic Informed Consent

I, the undersigned, have voluntarily requested that Dr. Senyi Ly assist me in the management of my health concerns. I have understood and agree to all policies and terms provided in the office policies and procedures. I understand that Dr. Ly is a chiropractor and that his services are not to be construed or served as a substitute for standard medical care. Dr. Ly recommends that I undergo regular routine medical check-ups by my medical doctor. Medical doctors, doctors of chiropractic, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving the movement of the joints and soft tissues. Physical therapy, home exercises, and nutritional supplements/dietary recommendations may also be used. Routine chiropractic examination and treatment involve some of the following methods:

- Observation: General assessment of body and facial structures.
- Inspection: Specific visualization of body and facial structures. Visualization includes general body viewing in a standing position, front, back, and side. All symptomatic body structures may also be viewed. Women may continue wearing their bra in the course of examination unless it obscures visualization of injured/abnormal body structures.
- Auscultation: Using a stethoscope to listen for blood pressure and other body sounds.
- Palpation: The doctor will feel for tenderness, heat, swelling, and nodularity, laxity/integrity of tissues, and other abnormalities.
- Percussion: The doctor may use a rubber hammer or their fingertips to tap on bones or tendons.
- Orthopedic/neurological testing: These are standard tests to assess your neuromusculoskeletal system.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated.

Risks for treatment

Soreness: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform the doctor if you experience these symptoms.
Fractures/joint injury: I further understand that in isolated cases underlined physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in one million is about the same chance is getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical therapy burns: some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.

A thorough health history and tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment results

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing. I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

Alternative treatments available

Reasonable alternatives to these procedures have been explained to me including non-treatment, rest, home applications of therapy, exercises and referral to primary care provider for medications or possible surgery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

Rest: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapies. Prolonged bed rest can contribute to weakened bones and joint stiffness.

Medications: Medications can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Surgery: Surgery may be necessary for conditions such as joint instability or serious disc rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

I have read or have had read to me the above explanation of chiropractic treatment. The doctor has also asked me if I want a more detailed explanation; but I am satisfied with the explanation and do not want any further information. I have made my decision voluntarily and freely. To attest to my consent to these examination and treatment procedures, I hereby affix my signature to this informed consent document.

_____ _____

Patient Signature Date

I explained the procedures, alternatives, and risks in conference with the patient.

_____ _____

Doctor's signature Date

Financial Policy Summary

Soma Chiro & Functional Medicine

Notice

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If you are in a health care plan such as BCBS, Health Partners, and United, etc. Unfortunately, we are currently out of network with all health care plans.
- However, we are a network provider with ChiroHealth USA that you may choose to join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), will be entitled to network discounts similar to insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our team for more information.

As part of our compliance plan, as of _____11/12/2018_____ our office will be unable to extend any type of discounts other than those listed above.

Acknowledged by: _____Date: _____