

Welcome to  
**COMPLETE CHIROPRACTIC, INC.**

Dr. Grant L. Modory, D.C.  
708 Schilling Drive, Suite 5  
Dundas, MN 55019  
507-645-0333

**Outline of Procedure for New Patients**

1. **STEP ONE:** All new patients are requested to fill out a personal health/history questionnaire.
2. **STEP TWO:** Your first consultation with a doctor to discuss your health problems.
3. **STEP THREE:** Diagnostic chiropractic, orthopedic and neurological examination procedures to determine if chiropractic care is appropriate for your condition.
4. **STEP FOUR:** The doctor will advise you as to the need of additional procedures such as laboratory and x-ray tests, if necessary.
5. **STEP FIVE:** If your case requires immediate attention, emergency first aid will be administered.
6. **STEP SIX:** You will be advised as to a time you can return for your "Report of Findings" when your doctor will inform you as to your examination results and whether or not your case has been accepted. You will also be advised concerning financial arrangements and insurance coverage as appropriate.
7. **STEP SEVEN:** After you return and receive your report of findings your recommended treatment program will be explained to you.
8. **STEP EIGHT:** Treatments will begin and continue as scheduled until your condition has been fully corrected, or until the maximum possible improvement has been obtained.

**PERSONAL HISTORY**

Date: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_  
(first, middle initial, & last)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

Business/Employer: \_\_\_\_\_

Type of Work: \_\_\_\_\_

Check One:  Married  Single  Widowed  Divorced  Separated  No. of Children \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Referred to this Office by: \_\_\_\_\_

Who is responsible for your bill?  Self  Spouse  Workman's Comp.  Medicaid  Medicare  
 Auto Insurance  Personal Health Insurance  Other \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Employed by: \_\_\_\_\_ Business Phone: \_\_\_\_\_

## CURRENT HEALTH CONDITION

Current health problems:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Other Doctors seen for this condition: \_\_\_\_\_

When did each condition begin?: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

What do **you** think is wrong?: \_\_\_\_\_

If disabled from work, please give dates: \_\_\_\_\_

Job Related  Auto Related

---

## PAST HEALTH HISTORY

*Please Check or Describe:*

Major Surgery/Operations:  Appendectomy  Tonsillectomy  Gall Bladder  
 Hernia  Broken Bones  Hysterectomy

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

Accidents or Falls: \_\_\_\_\_

Fender Benders: \_\_\_\_\_

Have you ever been knocked unconscious? \_\_\_\_\_

Hospitalization (Other than above): \_\_\_\_\_

Have you been x-rayed in the last year?  Yes  No

Date and Place: \_\_\_\_\_  Spine  Extremity  Chest

Explain any extreme mental, chemical (toxic) or physical stress you have been exposed to in the past or present:

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

Previous Chiropractic Care:

None  Doctor's name and approximate date of last visit: \_\_\_\_\_

Have you been treated for any health condition in the last year?  Yes  No

If yes, please explain:

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

---

## FAMILY HISTORY

Past and Present Health Problems

Mother (age) \_\_\_\_\_

Father (Age) \_\_\_\_\_

Brothers \_\_\_\_\_

Sisters \_\_\_\_\_

# PATIENT HEALTH QUESTIONNAIRE

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

In the space below, please describe your major complaint. If you have an additional complaint(s), please describe on an additional page.

1. Please describe your complaint: \_\_\_\_\_  
 \_\_\_\_\_

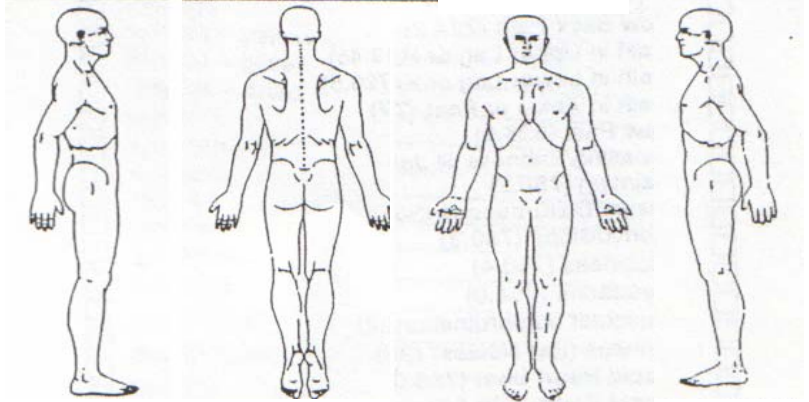
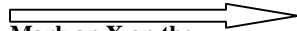
**a. Description:**

- Sharp Pain
- Dull Pain
- Ache
- Weak
- Throbbing
- Numb
- Shooting
- Gripping
- Burning
- Tingling

**b. Frequency**

- Constant (76 – 100%)
- Frequent (51 – 75%)
- Occasional (26 – 50%)
- Intermittent (25% or less)

Mark an X on the picture where you have pain or other symptoms.



**c. Intensity:** (circle appropriate number) No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

**d. Have your symptoms**  decreased  not changed  increased

**e. Symptoms are worse in the**  morning  afternoon  night  
 increases during the day  same all day

2. a. How long has your problem been present? \_\_\_\_\_ days \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years.  
 b. If it followed a specific incident, please date & describe: \_\_\_\_\_

c. If from lifting, how many lbs? \_\_\_\_\_ In what position were you?  bent forward  bent backwards  knees bent  twisted

3. What doctors/providers have you seen for this episode?  DC  MD  DO  PT  
 Currently are seeing?  DC  MD  DO  PT  None  Other: \_\_\_\_\_

a. Examinations included:  X-Rays \_\_\_\_\_  MRI \_\_\_\_\_  CT \_\_\_\_\_  Other \_\_\_\_\_  
 (date) (date) (date)

Comments: \_\_\_\_\_

b. Treatment(s) included:  Exercise  Heat  Cold  Medications  Support  Electrical Therapy  Manipulation  Surgery  
 Comments: \_\_\_\_\_

4. In the past have you been treated for the same or a similar problem?  Yes  No If yes, when? \_\_\_\_\_  
 Type of provider seen?  DC  MD  DO  PT  Other \_\_\_\_\_

5. What makes your problem better?  Lying Down  Walking  Standing  Sitting  Movement/Exercise  Inactivity

6. What makes your problem worse?  Lying Down  Walking  Standing  Sitting  Movement/Exercise  Inactivity

7. How would you rate your general stress level?  Little or No Stress  Minimal Stress  Moderate Stress  Greatly Stressed

8. General Physical Activity:  No regular exercise program  Light exercise program  
 Moderate exercise program  Strenuous exercise program  
 If exercising, typical type of exercise being performed? \_\_\_\_\_

9. Physical activity at work:  Sitting more than 50% of workday  Light manual labor  
 Manual labor  Heavy manual labor  Repeated motion

10. Occupation: \_\_\_\_\_  Full Time  Part Time  
 Has your work status changed because of this complaint?  Yes  No

11. What is your current work status?  
 Full time, no restrictions  Part time, no restrictions  Off work due to restrictions  Retired  Full time student  
 Full time, with restrictions  Part time, with restrictions  Unemployed  Full time homemaker  Other: \_\_\_\_\_

**For Doctors Use Only**

Present complaint: \_\_\_\_\_  
 Date of Onset: \_\_\_\_\_ Mechanism of Onset/ADL: \_\_\_\_\_ Back Index \_\_\_\_\_  
 Prior Treatment and Response for this complaint: \_\_\_\_\_ Neck Index \_\_\_\_\_  
 Pre-Existing Status of Problem Area: \_\_\_\_\_

If you have ever had a listed condition in the past, please check it in the **Past** column. If you are presently troubled by a particular condition, check the **Present** column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

<b>Past</b>	<b>Present</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain (723.1)
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain (719.41)
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow (719.42)
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain (719.44)
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain (719.43)
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain (724.1)
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain (724.2)
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip (719.45)
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee (729.5)
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot (719.47)
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain (526.9)
<input type="checkbox"/>	<input type="checkbox"/>	Swelling/Stiffness of Joint(s)
<input type="checkbox"/>	<input type="checkbox"/>	Fainting (780.2)
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances (368.9)
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions (780.3)
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness (780.4)
<input type="checkbox"/>	<input type="checkbox"/>	Headache (784.0)
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination (781.3)
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Noises) (388.30)
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat (785.0)
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains (786.50)
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite (783.0)
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia (307.1)
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight <input type="checkbox"/> Gain (783.1) <input type="checkbox"/> Loss (783.2)
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst (783.5)
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough (786.2)
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis (473.9)
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue (780.7)
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow (626.4)
<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow (626.7)
<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness/Lumps (611.72)
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis (617.9)
<input type="checkbox"/>	<input type="checkbox"/>	PMS (625.4)
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control (788.30)
<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination (788.1)
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination (788.41)
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain (789.0)
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Irregular Bowel Habits (564.0)
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing (787.2)
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion (787.1)
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash (692.9)

<b>Past</b>	<b>Present</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Depression (311)
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm (441.5)
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure (401.9)
<input type="checkbox"/>	<input type="checkbox"/>	Angina (413.9)
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (410.9)
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (436)
<input type="checkbox"/>	<input type="checkbox"/>	Asthma (493.9)
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (199.1)
<input type="checkbox"/>	<input type="checkbox"/>	Tumor (229.9)
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems (601.9)
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder (790.6)
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (chronic lung disorders) (492.8)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (716.9)
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis (714.0)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (250.0)
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (349.5)
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer (556.9)
<input type="checkbox"/>	<input type="checkbox"/>	Liver (573.9)/Gallbladder (575.9) problems
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones (592.0)
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (573.3)
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection (595.9)
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders (by condition)
<input type="checkbox"/>	<input type="checkbox"/>	Colitis (558.9)
<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon (564.1)
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS (042)
<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

**If a family member has had any of the following please mark the appropriate box:**

<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Chronic Back Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic Headaches
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Lupus
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Other Conditions _____
<input type="checkbox"/> High Blood Pressure	_____

<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have permanent disability rating?
<input type="checkbox"/>	<input type="checkbox"/>	Location _____
<input type="checkbox"/>	<input type="checkbox"/>	Date rating received ___/___/___
<input type="checkbox"/>	<input type="checkbox"/>	Rating Percentage _____%

**Present: Weight** \_\_\_\_\_ pounds **Height** \_\_\_\_\_ feet \_\_\_\_\_ inches

**Please check any of the following that apply to you:**

<b>Past</b>	<b>Present</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy (V22.2)
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Medications (list if not listed elsewhere)
		_____
		_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization/Surgical Procedures (list if not described elsewhere) _____

<b>Past</b>	<b>Present</b>	
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco (305.1)
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol (305.0)
<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence (303.9)
<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffeinated Soft Drinks:
		cups/cans per day _____
		_____

**Patient' Signature:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

**DOCTOR'S ADDITIONAL COMMENTS/GENERAL HEALTH CONCERNS:**

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

### DIETARY SURVEY

Please write down the approximate number of glasses or servings of the following food items you consume each **week**.

1.	whole milk	_____	6.	potatoes	_____
	skim milk	_____		carrots	_____
	cream	_____		beans – yellow	_____
	buttermilk	_____		beans – green	_____
	soy milk	_____		beans – dried	_____
	cheese	_____		corn	_____
	(what kinds?)	_____		squash	_____
	yogurt	_____		spinach	_____
2.	eggs	_____		lettuce	_____
	beef	_____		celery	_____
	pork	_____		green peas	_____
	veal	_____		broccoli	_____
	liver	_____		cauliflower	_____
	bacon	_____		asparagus	_____
	fowl	_____		onions	_____
	fish	_____		tomatoes	_____
	shell fish	_____		green peppers	_____
	lunch meat	_____		cabbage	_____
	canned meat	_____		turnips	_____
3.	cereals – hot	_____		beets	_____
	cereals – cold	_____		others	_____
	sugar coated	_____	7.	oranges	_____
	pancakes	_____		grapefruit	_____
	waffles	_____		pineapple	_____
	crackers	_____		melon	_____
	rice-brown	_____		apples	_____
	rice-white	_____		pears	_____
	rice-wild	_____		bananas	_____
	macaroni	_____		grapes	_____
	spaghetti	_____		raisins	_____
	soup-canned	_____		apricots	_____
	soup-fresh	_____		peaches	_____
4.	pie	_____		plums	_____
	cake	_____		strawberries	_____
	gelatin/pudding	_____		raspberries	_____
	candy	_____		blueberries	_____
	candy bars	_____		others	_____
	cookies	_____	8.	peanuts	_____
	doughnuts	_____		peanut butter	_____
	ice cream	_____		other nuts	_____
	chips	_____		jellies	_____
5.	juice	_____		mayonnaise	_____
	(what kinds?)	_____		ketchup	_____
	soda/pop	_____	9.	bread slices:	_____
	spring water	_____		wheat	_____
	water-city	_____		white	_____
	water-well	_____		rye	_____
	beer	_____		corn	_____
	wine	_____		sweet	_____
	other alcohol drinks	_____		other	_____

Continued...

10. pats of:  
butter \_\_\_\_\_  
margarine \_\_\_\_\_

11. cups of:  
coffee-regular \_\_\_\_\_  
coffee-decaf \_\_\_\_\_  
non-herbal tea \_\_\_\_\_  
herbal tea \_\_\_\_\_

12. Number of times per week you eat out/drive through and pick up food at "fast food" restaurants? \_\_\_\_\_

**Additional Dietary Questions:**

12. What vegetable oil do you use for:  
Cooking? \_\_\_\_\_ Salads? \_\_\_\_\_

13. Do you use any fats or compounds when cooking?  yes  no  
If yes, what kinds? \_\_\_\_\_

14. How often do you use salt?  
 Freely  Moderately  Sparingly  Never

15. How often do you use vinegar  
 Freely  Moderately  Sparingly  Never

16. If you add sugar to tea, coffee, or other foods at the table; about how many teaspoonfuls do you add each day? \_\_\_\_\_

17. Do the answers on this survey reflect your average diet over the past three years?  yes  no  
Comments: \_\_\_\_\_

18. What foods, if any, disagree with you?  
\_\_\_\_\_

19. Do you experience indigestion?  yes  no If yes, how frequently? \_\_\_\_\_

20. What did you have for breakfast yesterday?  
\_\_\_\_\_

21. What did you have for lunch yesterday?  
\_\_\_\_\_

22. What did you have for dinner/supper yesterday?  
\_\_\_\_\_

23. What beverages did you drink yesterday?  
\_\_\_\_\_

24. Did you eat any food or drink any beverages between meals?  yes  no

25. Are you fond of:  
meats  yes  no  
fruits  yes  no  
vegetables  yes  no  
breads  yes  no  
cereals  yes  no  
sweets  yes  no  
fats  yes  no  
butter  yes  no

---

**For Doctors Use Only:**

**PURPOSE**

The purpose of our chiropractic center is to support each individual in achieving their optimum health and to educate them so that they may understand health and chiropractic and in turn educate others.

**INFORMATION ABOUT APPLIED KINESIOLOGY AND CONTACT REFLEX ANALYSIS IN MINNESOTA**

The Doctors of Chiropractic in this office have received education and training in the use of Applied Kinesiology (AK) and Contact Reflex Analysis (CRA) to assist in evaluating your body's nervous system. The practice of the AK was started by Dr. George Goodheart of Detroit, MI in 1964; while the practice of CRA was started by Dr. D.A. Versendaal of Holland, MI in 1962.

AK and CRA are utilized in other healing sciences. Some Doctors of Medicine, Optometry, and Dentistry and nurses have been trained in AK and CRA and use it to gain better insight in to body function. AK and CRA are not widely available.

While there has been some research and publications of AK and CRA in professional journals, some so the techniques of AK and CRA have not been supported by a body of evidence using standard scientific research and methodologies.

This office utilizes standard chiropractic testing procedures for diagnosing with additional support from AK and CRA.

I hereby agree to an examination utilizing standard testing procedures, AK and CRA. I also agree to treatment and therapy as agreed upon by the patient and Doctor.

-----  
**AGREEMENT AND RELEASE**

I authorize release of information to family physicians, my employer and/or insurance companies. I authorize the taking of photographs and x-rays to be used for treatment purposes. I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself and that, ultimately, I am financially responsible for all services rendered. I also understand that if I terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I authorize my insurance benefits to be paid directly to Grant Modory, D.C.      Yes \_\_\_      No \_\_\_

**Patient's Signature** \_\_\_\_\_      **Date** \_\_\_\_\_

-----  
Your appointment is a reservation of time. *If you cannot make your appointment, please give us 24 hours advance notice so that someone else may use it for their health needs.* If you do not notify us, a fee of 1/2 our regular visit charge will be assessed to your account.

I have read and I fully understand ALL of the above.

**Patient's signature** \_\_\_\_\_      **Date** \_\_\_\_\_

**Office Verification Signature** \_\_\_\_\_      **Date** \_\_\_\_\_

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information (PHI) we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

---

Signature of Patient

Date