8170 Old Carriage Court N. | Suite 200
Shakopee, Minnesota | 55379

phone 952.224.2909
fax 952.465.3901

Dear Patient:

Welcome to the Chiropractic Clinic of Dr. Chris Frykman. By choosing this particular type of health care, you have the opportunity to understand the concept of total person health and obtain information regarding your personal needs for a healthy body.

Dr. Frykman has received education and training in the use of Applied Kinesiology (AK), an advanced method of diagnosis which involves the use of muscle testing as a supplemental procedure in diagnosis, treatment, and/or nutritional recommendation.

Enclosed are several forms for you to read and complete so that your first visit to our clinic will be effective. Please read carefully the “Patient Information” sheet as it will help to answer questions about our procedures. The “New Patient Information” and “Detoxification Questionnaire” need to be filled out completely before your appointment. These comprehensive forms are very beneficial to the doctor in searching out the cause of your health concerns.

If you have any questions prior to your initial visit, please call our clinic at **(952) 224-2909**. We look forward to meeting you.

Yours in Health,

Chris Frykman, D.C.

PATIENT INFORMATION

APPOINTMENTS

In order to ensure that times are available to you, please check with staff to set up follow-up appointments. These appointments can be changed or cancelled at any time. Please give us at least 24 hour notice so that someone else that is waiting to get in may be notified. Thank you.

To expedite our patient schedule, please arrive before your appointment to allow for restroom use, etc. We are committed to our schedule and yours, although emergencies do occur.

EMERGENCY

Please call – staff and your doctor will do their best to assist you.

PAYMENT

Chiropractic care may be covered under your insurance policy (check with your agent), yet we request that you pay for your services as they are rendered. You will be reimbursed directly from your insurance company. In order to give you the highest quality care possible, we do not have agreements with insurance companies. This ensures that Dr. Frykman can render care based on what your body needs, not what a third party (insurance company) thinks is most cost effective.

MEDICARE/WORKER'S COMPENSATION

We do not accept Worker's Compensation claims. Medicare may not cover your visits.

AUTOMOBILE ACCIDENTS

We do not submit auto claims, but we will give you a coded receipt to submit (see below).

CLAIM SUBMITTING

A form will be provided at each visit by request that will provide all necessary information to submit to your insurance company.

FEE STRUCTURE

Complete Examination includes: full health history; comprehensive lab workup; muscle testing exam; physical, orthopedic, and neurological exam of entire body; treatment if appropriate. Approximate time: 1 hr. – Fee: $197

Focused Examination includes: focused history of present illness; muscle testing exam; physical, orthopedic, and neurological exam of problem area; treatment if appropriate. Approximate time: 30 minutes – Fee: $97

Both levels of examination include a complete report of findings. This is a subsequent visit that will be scheduled at least one day after the initial exam. In the report of findings your doctor will go over all exam findings and share the treatment plan. Patients spouses are encourage to attend so that everyone in the household understands what is happening during care. This will result in optimal support of the patients needs both at the office and at home.

Office Visit includes: Any and all spinal, extremity, pelvic, and cranial or visceral adjustments; brief advice on nutrition, exercise; any modality needed; neurologic reprogramming; food sensitivity testing. Approximate time: 15 min. Fee: $59.00

Qigong Visit includes: Grounding; clearing major energy meridians; restoring optimal energy flow to your body. Approximate time: 15 min. Fee: $59.00

Additional Costs include: re-exams, nutritional supplements, special programs and orthopedic appliances.

If you have questions about what services you require you may consult our website at ***www.vibrantpotential.com****, call the receptionist at* ***952-224-2909*** *and request a list of services to be mailed/faxed to you, or you may request to speak with* ***Dr. Frykman*** *directly.*

Our intent is to support you with the most effective and cost-efficient care possible in facilitating your optimal health.

Yours in health,
Chris Frykman, D.C.

NEW PATIENT INFORMATION

Welcome! Please print clearly and read all information carefully. Date: _____ / _____ / _____

ABOUT YOU

Full Name: ____

Gender: ☐ M ☐ F Age: _____ DOB: _____ / _____ / _____

Email Address: ____

Street Address: ____

City, State, Zip: ____

Home Phone: ______________________________ Cell Phone: ______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of Spouse / Significant Other if applicable: ____

Anniversary: _____ / _____ / _____

Employer: ______________________________ Occupation: ______________________________

WHOM MAY WE THANK FOR THE REFERRAL?: _______________________________________

EMERGENCY CONTACT

Name: ______________________________ Relation: ______________________________

Daytime Phone: ______________________________ Other Phone: ______________________________

REASON FOR YOUR VISIT

If you have no specific symptoms or complaints, and you are here for Performance Care and Chiropractic Wellness Services, please check (X) here _____ and skip to the Past History section of this form. All others please answer the following questions pertaining to your complaint.

If you are experiencing pain, is it... ☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing

Please use the figures below to accurately mark the areas in which you feel the sensations.

Rate your pain on a scale of 1-10, 10 being the worst: _____

Since the problem started, it is... ☐ Getting Better ☐ Getting Worse ☐ About the Same

How frequent is the condition? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night Only

How long does it last? ☐ All Day ☐ Few Hours ☐ Minutes

Is the condition interfering with your: ☐ Work ☐ Sleep ☐ Training ☐ Daily Routine

What makes it worse? ____

Is there anything you can do to relieve the problem? ____

Has another doctor treated you for this problem? ☐ Y ☐ N

Please list the contact information below.

Chiropractors: ____

Medical Doctors: ____

Others: ____

Were x-rays or other imaging procedures performed? ☐ Y ☐ N

When did you first seek treatment for this problem? ____

What do you believe is wrong with you? ____

Are there any other conditions or symptoms that may be related to your major symptom? ☐ Y ☐ N

If yes, what? ____

Have you ever been in an auto accident? ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years ☐ Never

PAST HISTORY

At Vibrant Potential we focus on your ability to be healthy. Our goals are first to address the issues that brought you to the office, and second, to offer you the opportunity for improved health potential and optimal daily performance. On a daily basis we experience physical, chemical, and mental stress that can accumulate and result in a serious loss of health. Most of the time the effects are gradual, not even felt until they become more serious and the body can no longer adapt. Answering the following questions will give us a profile of the specific stresses that you have faced in your lifetime, allowing us to better assess the challenges to achieving your optimal health and performance.

Please check all symptoms you now have or have had previously, even if they do not seem related to your current problem.

☐ Headache
☐ Back Pain
☐ Neck Pain
☐ Stiff Neck
☐ Fever
☐ Fainting
☐ Fatigue
☐ Blurred Vision
☐ Earache
☐ Ringing in Ears
☐ Loss of Smell
☐ Trouble Swallowing
☐ Sinusitis
☐ Sleeping Problems
☐ Teeth Grinding
☐ Cold Sweats
☐ Hot Flashes
☐ Menstrual Irritability
☐ Irregular Cycle
☐ Lumps in Breast

☐ Constipation
☐ Hemorrhoids
☐ Trouble Urinating
☐ Kidney Stones of Infection
☐ Stomach Upset
☐ Heartburn
☐ Weak Muscles
☐ Paralysis
☐ Shakiness
☐ Hip Pain
☐ Knee Pain
☐ Shoulder Pain
☐ Cold Feet
☐ Cold Hands
☐ Frequent Urination
☐ Dry Hands
☐ Irritability
☐ Nervousness
☐ Diarrhea
☐ Pins and Needles in Arms

☐ Pins and Needles in Legs
☐ Numbness in Hands
☐ Numbness in Feet
☐ Joint Stiffness
☐ Swollen Ankles
☐ Rapid Heart Rate
☐ Slow Heart Rate
☐ Chest Pain
☐ Wheezing
☐ Chronic Cough
☐ Dizziness
☐ Bruise Easily
☐ Varicose Veins
☐ Skin Eruptions (Rash)
☐ Depression
☐ Mood Swings
☐ Fractures
☐ Sprain / Strain
☐ Other
☐ ____________________

SCARS / SURGICAL PROCEDURES

Please list all scars and surgical procedures you have had:

____

YOUR HABITS

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Smoke / Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Stress Level	☐	☐	☐	☐

WORK ACTIVITY

☐ Heavy Labor ☐ Light Labor
☐ Mostly Sitting ☐ Mostly Standing
☐ Driving ☐ Walking / Moving

SUPPLEMENTS

Do you take vitamins / minerals or herbs? ☐ Y ☐ N

If yes, please list them here:

____

If yes, who recommended them?

____

Do you take muscle gain or weight loss supplements? ☐ Y ☐ N

Do you take any prescription medications? ☐ Y ☐ N

If yes, please list them here:

____

YOUR DAILY ROUTINE

How often do you exercise? ☐ 5-7 days/ week ☐ 3-4 days/ week ☐ 1-2 days/ week ☐ None

What kind?
☐ Running ☐ Walking ☐ Hiking ☐ Cycling
☐ Elliptical Trainer ☐ Stair Climber ☐ Weight Lifting ☐ Circuit Training
☐ Kickboxing ☐ Yoga/ Pilates ☐ Dancing ☐ Duathlon/ Triathlon
☐ Other: _______________

Do you play sports? ☐ Y ☐ N

If yes, which ones? ____

What is your average water intake per day? ☐ 64+ oz. ☐ 32-64 oz. ☐ 16-32 oz. ☐ <8 oz.

How many bowel movements do you have? ☐ 1 ☐ 2 ☐ 3 per day/week *(circle one)*

How many meals do you eat per day? ☐ 5+ ☐ 4 ☐ 3 ☐ 2 ☐ 1

How many hours of sleep do you get at night? ☐ 8+ hrs. ☐ 7-8 hrs. ☐ 6-7 hrs. ☐ 5-6 hrs. ☐ <5 hrs.

On a scale of 1-10, 10 being the best, rate your overall level of health: _______ out of 10.

FAMILY HISTORY

Please check any and all that apply:

Grandparents:	☐ heart disease	☐ cancer stroke	☐ diabetes	☐ high blood pressure	☐ other: __________
Mother:	☐ heart disease	☐ cancer stroke	☐ diabetes	☐ high blood pressure	☐ other: __________
Father:	☐ heart disease	☐ cancer stroke	☐ diabetes	☐ high blood pressure	☐ other: __________
Siblings:	☐ heart disease	☐ cancer stroke	☐ diabetes	☐ high blood pressure	☐ other: __________

TREATMENT

What type of treatment are you looking for?

☐ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.

☐ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.

☐ I am looking to take care of my problem and then go on to "performance & wellness care" to achieve my optimal health.

Goals of Care (why you are here in your own words):

I understand that the above information and the statements made on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in medical status. I authorize Dr. Chris Frykman to perform any necessary services during diagnosis and treatment, and I am willing to accept responsibility for myself, and reserve the right to accept or reject any recommendations made. I understand that some of the results of my examination may be used for research.

I understand and agree that insurance policies are arrangements between my insurance carrier and myself, and that it is I who am responsible for my bill. Furthermore, I understand that Vibrant Potential will prepare any necessary reports or forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Vibrant Potential will be credited to my account on receipt. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will become immediately due and payable.

______________________________ ____________

Signature Date

Authorization for care of a minor:

I hereby authorize Vibrant Potential and its doctor to administer care as they so deem necessary to my son / daughter.

______________________________ ____________

Signature of Parent / Guardian Date