About the Patient

Name _____

Address_____

City_____ State_____ Zip_____

Home Phone (_____) _____

Cell Phone (_____) _____

Birthday _____/_____/_____ Age_____

Gender (circle one) M F Number of Children _____

Employer_____

Work Phone _____

Type of Work _____

Marital Status: Married Single Divorced Other

How did you hear about our office: _____

Email Address _____

Social Security # _____

Payment Method Cash Check Credit

Card CC#_____

Exp:_____ CID #_____

About the Spouse or Parent

Name _____

Work Phone _____

Back To Wellness

Chiropractic & Acupuncture

My Health Insurance

Insurance company _____

Policy # _____

Address _____

Group # _____

Phone Number _____

Primary Care Physician: _____

About the Insured Person

Name _____

Insured's SSN _____

Relation to insured _____

Date of Birth _____

Emergency Contact

Name _____

Relationship _____

Work Phone _____

Home Phone _____

AUTHORIZATION FOR CARE ~ TITLEIST PERFORMANCE INSTITUTE PROGRAMS

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, and/or other therapies as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payments. I agree that I am responsibly for all the bills incurred at the office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I understand that the TPI Programs are performance based and are not intended to treat or manage pain symptoms. I understand that I am fully responsible for payment and insurance cannot be used to enhance performance. If a new condition arises during the course of my care, I will notify the Doctor immediately and my insurance will be verified for coverage.

_____ _____

Patient's signature Date Patient's signature Date

Ownership of X-Ray Films

It is understood and agreed that the payments to the Doctor for X-Rays is for examination of X-Rays only. The X-Ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

BACK TO WELLNESS NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At BACK TO WELLNESS, we have always kept your health records secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the term of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care may be allowed access to your file.

We may use or disclose your health information for payment for our services. For example, we may send a report of your progress to the insurance company.

We may use or disclose your health information for our normal health care operations. For example, staff may enter your information into our records.

We may share your medical information with our business associate, such as a billing service. We have written a contract with each associate to protect your privacy.

We may use your information to contact you. For example, we may send you a card or letter, we may also need to call and remind you of an appointment. If you are not available we may leave the information on your answering machine or with whoever answers the phone.

In an emergency, we may disclose your health information to a family member or any other person responsible for your care (such as E.M.T.'s or paramedics.)

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your permission.

You may request in writing that we may not use or disclose your health information as described above. We will let you know if we can comply with your request.

You have the right to know of any uses or disclosures we make with your health information beyond the normal uses.

As we need to contact you from time to time, we will use whatever address and phone number you prefer us to contact you at.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with few exceptions. Give us a written request regarding the information you wish to see. We may charge you a fee for copies released to your care.

You have the right to receive a copy of this notice. If we change any of the details of this notice we will notify you in writing.

You may file a complaint with THE DEPARTMENT OF HEALTH AND HUMAN SERVICES at 200 Independence Ave. S.W., Room 509F, Washingion, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our PRIVACY OFFICERS, DR. MATTHEW DERRY, D.C. or DR. TANJA SUKOVIC DERRY, at (720) 851-7400.

This notice goes into effect on May 1, 2008.

Acknowledgment I have reviewed a copy of the BACK TO WELLNESS, L.L.C. notice of privacy practices.

Print Name_____

Signature_____Date_____

If signing as a parent or guardian, please now the name of the patient_____

TPI PERFORMANCE QUESTIONAIRE

Please answer the following questions to the best of your ability regarding your current golf ability:

Do you have any previous injuries? _____

If yes, please list them? _____

Do any of the following positions in golf cause pain? If yes, where at? _____

Set-up Backswing Transition Downswing Impact Follow Through

Do you have any physical limitations?_____

Do you usually warm up prior to playing or practicing? If yes, how long?_____

Do you workout on a regular basis? If yes, how frequent?_____

How would you rate your current physical condition: Excellent Good Fair Poor

Are you right or left handed? Right Left Do you swing right or left handed? Right Left

What is your current handicap? _____

How often do you practice during a week? _____

What are your long term performance goals? _____

_____

What problem areas are present in your current golf game?

Inconsistent ball striking Lack of Power Accuracy Slicing / Hooking Endurance

What is the strongest part of your game?_____

What area of your game needs the most work? _____

Are you a member at a golf club? If yes, which one? _____

Are you currently taking lessons? If yes, how long? _____

What are your expectations from our TPI Program? _____

_____

Have you been enrolled in a performance golf program before? If yes, what were your results? _____

_____

Additional Comments: _____

_____

_____

_____

Experience With Chiropractic

Have you been adjusted by a Chiropractor before? Yes No

Reason for those visits? _____

Was the care helpful? _____

Dr.'s name _____

Approximate date of last visit? _____

DOCTOR'S COMMENTS:

Confidential Health History

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

OCCASIONAL / FREQUENT

GENERAL
- ☐ ☐ Allergy (list below)*
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness or fainting
- ☐ ☐ Headache
- ☐ ☐ Neuralgia
- ☐ ☐ Numbness

MUSCLE
- ☐ ☐ Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Foot trouble
- ☐ ☐ Low back pain or stiffness
- ☐ ☐ Pain between shoulders
- ☐ ☐ Sciatica
- ☐ ☐ Swollen joints

Pain, numbness or Cramps
- ☐ ☐ Shoulders
- ☐ ☐ Arms
- ☐ ☐ Elbows
- ☐ ☐ Hands
- ☐ ☐ Hips
- ☐ ☐ Legs
- ☐ ☐ Knees
- ☐ ☐ Feet

GASTRO-INTESTINAL
- ☐ ☐ Colon trouble
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Difficult digesting
- ☐ ☐ Gall bladder trouble
- ☐ ☐ Hemorrhoids
- ☐ ☐ Liver trouble
- ☐ ☐ Pain over stomach

EYES, EARS, NOSE & THROAT
- ☐ ☐ Asthma
- ☐ ☐ Colds
- ☐ ☐ Deafness
- ☐ ☐ Earache
- ☐ ☐ Ear discharge
- ☐ ☐ Ear noise
- ☐ ☐ Eye pain
- ☐ ☐ Nasal obstruction
- ☐ ☐ Sinus infection

CARDIO-VASCULAR
- ☐ ☐ Hardening of the arteries
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Pain over heart
- ☐ ☐ Poor circulation
- ☐ ☐ Rapid heart beat
- ☐ ☐ Swelling of ankles

RESPIRATORY
- ☐ ☐ Chest pain
- ☐ ☐ Chronic cough
- ☐ ☐ Difficult breathing
- ☐ ☐ Spitting up blood
- ☐ ☐ Spitting up phlegm
- ☐ ☐ Wheezing

SKIN
- ☐ ☐ Bruise easily
- ☐ ☐ Dryness
- ☐ ☐ Skin eruptions (rash)
- ☐ ☐ Varicose veins

GENITO-URINARY
- ☐ ☐ Bed-wetting
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Inadbility to control kidneys
- ☐ ☐ Kidney infection or stones
- ☐ ☐ Painful urination
- ☐ ☐ Prostate trouble
- ☐ ☐ Pus in urine

FOR WOMEN ONLY
- ☐ ☐ Congested breasts
- ☐ ☐ Cramps or backache
- ☐ ☐ Excessive menstrual flow
- ☐ ☐ Hot flashes
- ☐ ☐ irregular cycle
- ☐ ☐ Lumps in breast
- ☐ ☐ Menopausal symptoms
- ☐ ☐ Painful menstration
- ☐ ☐ Vaginal discharge

Pregnant ☐Yes ☐No
Date of last period_____
Previous miscarriages ☐Yes ☐No

DATE OF LAST: (Approx.)
- _____Physical examination
- _____Blood test
- _____Chest x-ray
- _____Spinal x-ray
- _____Dental x-ray
- _____Urine test

	NONE	LIGHT	MODERATE	HEAVY
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐

HAVE YOU EVER:
- ☐ Been knocked unconscious?
- ☐ Used a crutch, or other support?
- ☐ Been treated for a spine or nerve disorder?
- ☐ Had a fractured bone?
- ☐ Been hospitalized for other than surgery?
- ☐ Ever had surgery? (list below)

*Please list any prescription drugs now taken, allergies and past surgeries-_____

_____

_____

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS

☐ Aids	☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Pneumonia	☐ Tuberculosis
☐ Alcoholism	☐ Chicken Pox	☐ Foot Problems	☐ Measles	☐ Polio	☐ Typhoid Fever
☐ Anemia	☐ Diabetes	☐ Goiter	☐ Multiple Sclerosis	☐ Rheumatic Fever	☐ Ulcers
☐ Appendicitis	☐ Eczema	☐ Gout	☐ Mumps	☐ Scarlet Fever	☐ Venereal Disease
☐ Arteriosclerosis	☐ Emphysema	☐ Heart Disease	☐ Pacemaker	☐ Stroke	

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Sign your name_____Date_____

FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE
CASE HISTORY

Is there anything else you would like the doctor to know before you begin? _____

_____

_____

If you do not know or do not understand some of the techniques or procedures that Back To Wellness Chiropractic and Acupuncture uses to assist you in reaching all your health goals, PLEASE ASK!!