Bluebird Chiropractic
(970) 685-4461
www.BluebirdChiropractic.com

Dr. Katie Holzworth
1268 N CLEVELAND AVE
Loveland, CO 80537

CONFIDENTIAL HEALTH INFORMATION

Date (MM/DD/YYYY)

Last Name

First Name, Middle Name

Address

City, State Zip

Email Address

Occupation

Employer

Age

Gender

Home Phone

Cell Phone

Preferred Method of Contact

Emergency Contact

Emergency Contact's Phone

Birth Date

Marital Status

Spouse's Name

Child/Children's Name and Age

** We currently are not taking any insurances so do not fill in information below**

Primary Care Provider's Name

Relationship to Insured

Birth Date

Insured's Last Name

Social Security Number

Insured's First Name, Middle Name

Insurance Carrier

Insured's Employer

Policy Number

Address

City, State Zip

Please allow our staff to photocopy your driver's license and insurance details.

All information you supply is confidential. We comply with all federal privacy standards.

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Have you consulted a Chiropractor before? _____

Whom and when?_____

How did you hear about our clinic?_____

Symptom(s) that prompted you to come in:_____

_____

Symptom(s) are the result of: (check which apply)

( ) Accident or injury
( ) Worsening long term problem
( ) An interest in wellness
( ) Other_____

Onset (when did the symptom(s) start?)_____

_____

Intensity (circle number that best describes pain)

0-1-2-3-4-5-6-7-8-9-10
(absent) (agonizing)

Duration and Timing (check which apply)

( ) Constant
( ) Comes and goes
( ) Other_____

Quality of symptoms (check which apply and indicate on illustration)

( ) Numbness
( ) Tingling
( ) Stiffness
( ) Dull
( ) Aching
( ) Cramps
( ) Sharp
( ) Burning
( ) Shooting
( ) Throbbing
( ) Stabbing
( ) Other_____

Location (Please indicate on illustration)

"O" for current location
"X" for condition experienced in the past

What else should Dr. Katie know about your condition?

_____

How does your current condition effect the following:

Work:_____
Recreational activities:_____
Household responsibilities:_____
Personal relationships:_____
Sleep:_____
Other:_____

What is your preferred sleeping position?_____

Describe your typical eating habits: (check which apply)

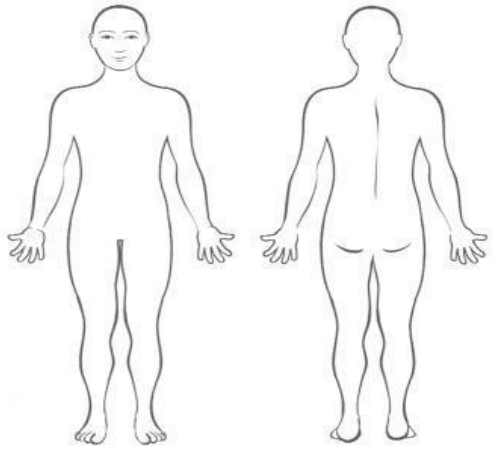
( ) Skip breakfast
( ) Two meals a day
( ) Three meals a day
( ) Snacking between meals

What would be the most significant thing you could do to improve your health?_____

_____

Any additional health goal?_____

_____



Musculoskeletal:

Have Had
( ) ( ) Osteoporosis
( ) ( ) Arthritis
( ) ( ) Knee injuries
( ) ( ) Foot/ankle pain
( ) ( ) Scoliosis
( ) ( ) Shoulder problems
( ) ( ) Neck pain
( ) ( ) Elbow/wrist pain
( ) ( ) Back problems
( ) ( ) TMJ issues
( ) ( ) Hip disorders
( ) ( ) Other_____
( ) None

Neurological:

Have Had
( ) ( ) Anxiety
( ) ( ) Depression
( ) ( ) Headaches
( ) ( ) Dizziness
( ) ( ) Pins and needles
( ) ( ) Numbness
( ) ( ) Other_____
( ) None

Skin:

Have Had
( ) ( ) Cancer
( ) ( ) Rash / eczema
( ) ( ) Other_____
( ) None

Cardiovascular:

Have Had
( ) ( ) Chest pains
( ) ( ) High/low blood pressure
( ) ( ) Poor circulation
( ) ( ) Excessive bruising
( ) ( ) High cholesterol
( ) ( ) Other_____
( ) None

Respiratory:

Have Had
( ) ( ) Sinusitis
( ) ( ) Asthma
( ) ( ) Trouble breathing
( ) ( ) Chronic cough
( ) ( ) Other_____
( ) None

Digestive:

Have Had
( ) ( ) Abdominal pain
( ) ( ) Constipation
( ) ( ) Diarrhea
( ) ( ) Heart burn
( ) ( ) Ulcer
( ) ( ) Other_____
( ) None

Sensory:

Have Had
( ) ( ) Blurred vision
( ) ( ) Ringing ears
( ) ( ) Chronic ear infection
( ) ( ) Sensory loss
( ) ( ) Other_____
( ) None

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Endocrine:
Have Had
( ) ( ) Thyroid issues
( ) ( ) Immune disorders
( ) ( ) Hypoglycemia
( ) ( ) Frequent infection
( ) ( ) Swollen glands
( ) ( ) Low energy
( ) ( ) Other_____
( ) None

Genitourinary:
Have Had
( ) ( ) Kidney stones
( ) ( ) Infertility
( ) ( ) Painful urination
( ) ( ) Loss of bladder control
( ) ( ) Erectile dysfunction
( ) ( ) PMS symptoms
( ) ( ) Other_____
( ) None

Any other symptoms previously listed:

Illnesses:
Have Had
( ) ( ) **HIV /** AIDS
( ) ( ) Allergies
( ) ( ) Arteriosclerosis
( ) ( ) Cancer
( ) ( ) Diabetes
( ) ( ) Hemorrhoids
( ) ( ) Gout
( ) ( ) Heart Disease
( ) ( ) Hepatitis
( ) ( ) Angina
( ) ( ) Heart Attack
( ) ( ) Stroke
( ) ( ) Multiple Sclerosis
( ) ( ) Asthma
( ) ( ) Gallbladder
( ) ( ) Rheumatic fever
( ) ( ) Emphysema
( ) ( ) Arthritis
( ) ( ) Bladder infection
( ) ( ) Kidney Stones
( ) ( ) Other_____
( ) None

Operations:
Have Had
( ) ( ) Appendix removal
( ) ( ) Bypass surgery
( ) ( ) Cancer
( ) ( ) Cosmetic
( ) ( ) Elective
( ) ( ) Eye
( ) ( ) Hysterectomy
( ) ( ) Pacemaker
( ) ( ) Spine
( ) ( ) Tonsillectomy
( ) ( ) Vasectomy
( ) ( ) Other_____
( ) None

Injuries:
Have Had
( ) ( ) Fractured or broken bone
( ) ( ) Spine or nerve disorder
( ) ( ) Knocked unconscious
( ) ( ) Neck injury
( ) ( ) Other_____
( ) None

Treatments:
Have Had
( ) ( ) Antibiotics
( ) ( ) Birth Control
( ) ( ) Blood transfusions
( ) ( ) Chemotherapy
( ) ( ) Dialysis
( ) ( ) Hormone replacement
( ) ( ) Inhaler
( ) ( ) physical therapy
( ) ( ) Supplements
_____
_____
( ) ( ) Medications
_____
_____
( ) ( ) Other_____
( ) None

Social History:

Daily	Weekly	How much?		Daily	Weekly	How much?	
( )	( )	_____	Alcohol use	( )	( )	_____	Exercising
( )	( )	_____	Coffee use	( )	( )	_____	Pain relievers
( )	( )	_____	Tobacco use	( )	( )	_____	Soft drinks
( )	( )	_____	Marijuana use	( )	( )	_____	Water intake
( )	( )	_____	Recreational drug use	( )	( )	_____	Hobbies

Acknowledgements

(To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read statements and initial your agreement.)

Initials

_____**I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

_____**I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

_____**I realized that and X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

_____**I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.**

_____**I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

_____**To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor, please print the child's full name:

_____

Signature **Date (MM/DD/YYYY)**

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays, and physical therapy techniques on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now, or in the future render treatment to me while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to; fractures, disc injuries, dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with the office personnel the nature, purpose, and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Name(s) of Doctor Treating This Patient:

Katherine J. Holzworth D.C
1268 N Cleveland Ave
Loveland, Co 80537
(970) 685 – 4461

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Printed name of patient	Date (MM/DD/YYYY)
Signature of patient	Date (MM/DD/YYYY)
Signature of patient's representative	Date (MM/DD/YYYY)
Witness to patient's signature	Date (MM/DD/YYYY)
Translated by	Date (MM/DD/YYYY)

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PRIVACY CONFIDENTIALITY STATEMENT

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of Information:

We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment, or healthcare operations. Additional disclosures maybe necessary to comply with Workers' Compensation and Public Health Laws as well as Judicial proceedings. We may contact a family member or other authorized person in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless compelled to do so by legal authority. Further you will be contacted by phone or mail in the event a request for information in made.

Appointment reminder:

It is our policy to call your home or office in the event that an appointment is missed. If you are not at home we leave a message on your answering machine or with the person answering the phone. We will not leave any message that discloses confidential information. If you would like to use an alternate contact number, please inform us of the number you prefer on your Confidential Health Information forms.

Facility Set Up:

While our examination and treatment rooms are private, this office utilizes an open reception area. Staff and doctor will maintain policies to ensure privacy. If there is private information that you need to discuss, please request to have the discussion in a private room.

Your Rights:

- Send us a written request to see or procure a copy of the information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as other doctors or hospitals.
- Request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instances they may be prohibited by law.
- Request that we communicate with you about medical matters using reasonable alternative means or at and alternative address.
- Receive an accounting of our disclosures of you medical information, except when those disclosures are made for treatment, payment, or heath care operations, or the lay otherwise restricts the accounting.
- You have the right to inspect and have a copy of your health information. There is not a cost for the fist copy. Any copy thereafter with be $25.00.
- You have the right to amend your information. Please note that we have the right to disagree with your amendments. If there is a disagreement, you will be provided with information about our denial of your amendment and how you may appeal the denial of the amendment.
- You have a right to a copy of the notice upon request.

Complaints:

Complaints about your privacy rights and how your privacy is handled at this office can be directed to Dr. Katherine Holzworth by calling this office or directing a letter to her attention. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to:

DHHS (Office of Civil Rights)
200 Independence Ave. S.W.
Room 509F HHH Building
Washington, D.C. 20201

I have read this Privacy Notice and understand my rights contained in this notice. By signing this form I provide authorization and consent to use and disclose my protected health information as noted above.

_____

Patient Name (print)

_____

Patient's Signature Date (MM/DD/YYYY)