PATIENT HISTORY FORM

Welcome to McKinley Chiropractic. Our goal is to help you to the best of our ability. This requires that we learn about your illness/injury and about how you came to visit us. The questions below will help us to not overlook any important information. Please answer them briefly. Some of them may not apply to you, answer them as N/A. If you cannot remember specific dates, the month or approximate year will be helpful. If you cannot recall a requested name or place, draw a line through the space to greatly help us give you the best possible care.

NAME____AGE________ □ Male □ Female BIRTHDATE _____/_____/______
HOME ADDRESS____ APT OR SUITE______________
CITY_____________________________________STATE_____________ZIP_____________PRIMARY PHONE______________________
OCCUPATION____WORK PHONE________________________
HEIGHT_____________________________WEIGHT_____________________________SS#__________/__________/___________
How were you referred to our office? □ Insurance Company □ Walk-In □ Friend/Relative □ Internet □ Other________________________
Patient Referral Name____
Employer______________________________ In the event of an emergency who should we contact?_______________________________
Relation______________________________ Primary Phone ______________________ Secondary Phone ____________________
WOMEN – Are you or could you be pregnant? □ Yes □ No

CHIEF COMPLAINTS/MAIN PROBLEMS (List most severe first)

1. ____
2. ____
3. ____
4. ____

Date these problems began ______________________ Are you still working? □ Yes □ No Last day on the job ________________________

Did your problems begin following:

□ A fall □ Lifting □ Twisting □ Bending Over □ Work Injury □ Motorized Vehicle Accident □ Recreational Injury □ Sport Injury
□ No apparent cause □ Other____
Describe all the details of any accident, incident or the way these problems began: ____
____
____
Where is the location of your pain today? ____
Is your pain today: □ Worse □ Better □ The same compared to when it began?

What reduces the pain?

□ Lying down	□ Exercises	□ Muscle Relaxant Pills	□ Injections for pain
□ Sitting	□ Home exercises	□ Aspirin Anti-inflammatory Pills	□ Walking
□ Standing	□ Pain pills	□ Chiropractic Adjustments	□ Massage
□ Nothing	□ Other ________________		

What activities make it worse?

□ Exercises (during)	□ Standing	□ Bending backward	□ Driving
□ Exercises (after)	□ Walking	□ Coughing	□ Lying down
□ Sitting	□ Bending forward	□ Sneezing	□ Changing position

What is the time interval between attacks of pain? □ Constantly □ Daily □ Weekly □ Monthly □ Yearly
Have you been in constant pain since it began or is your pain intermittent? Describe: ____
____
Does your pain intensity vary throughout a 24 hour period? □ Yes □ No
Can you climb or descend stairs? □ Yes □ No
Have you noticed any: □ Numbness □ Tingling □ Sensitivity with your pain?
Do your arms/legs get weak with your pain? □ Yes □ No
Has your pain affected your sex life? □ Yes □ No
Do you have full control of your bladder & bowels? □ Yes □ No
What position do you have to be in at rest? □ Stand □ Sit □ Lying down

Choose the number which best answers the question:

0	2	4	6	8	10
None	**Mild**	**Discomforting**	**Distressing**	**Horrible**	**Excruciating**

________Your pain right now ________Your pain at its worst ________Your pain at its least
Is your pain and disability so severe that you would consider surgery for some relief? □ Yes □ No
Have you been hospitalized for your pain problem? □ Yes □ No Number of times:_____________ Dates: ____________________________

Please check what treatments you have had for this condition.

Treatment	DATE STARTED	DATE STOPPED
Chiropractic…………………………….	______________	______________
Acupuncture…………………………..	______________	______________
Physical Therapy……………………..	______________	______________
Home Stretching Exercises…………	______________	______________
Home Strengthening Exercises……	______________	______________
Epidural Block……………………….	______________	______________
Facet Block…………………………..	______________	______________
Neurological Consult………………..	______________	______________
Orthopedic Consult………………….	______________	______________
Pain Medication……………………..	______________	______________
Massage Therapy…………………..	______________	______________

Have you had any of these diagnostic studies?

Study	Yes	No
Diagnostic X-rays………………………	____	____
CT (computer tomography) scan……	____	____
Myelogram (x-ray with dye injection)...	____	____
Electromyogram (EMG)……………….	____	____
Nerve Conduction Velocity (NCV)…..	____	____
Discogram………………………………	____	____
MRI (Magnetic Resonance Imaging)…	____	____
Arthogram or Sonogram……………….	____	____
Blood Work……………………………..	____	____
DEXA Bone Scan………………………	____	____

PAST MEDICAL HISTORY

Circle if you currently have, or previously suffered from:

Condition				Condition			
Arthritis…………………..	Yes	No	When______________	Psoriasis…………………..	Yes	No	When______________
Asthma…………………..	Yes	No	When______________	Psychiatric or Emotional…	Yes	No	When______________
Cancer…………………..	Yes	No	When______________	Rheumatic Fever…………	Yes	No	When______________
Diabetes…………………	Yes	No	When______________	STD's……………………..	Yes	No	When______________
Emphysema……………	Yes	No	When______________	Stroke…………………….	Yes	No	When______________
Gastritis…………………	Yes	No	When______________	Thyroid Disorders………..	Yes	No	When______________
Glaucoma………………..	Yes	No	When______________	Transient Ischemic………	Yes	No	When______________
Heart Disease…………..	Yes	No	When______________	Tuberculosis……………..	Yes	No	When______________
HIV+/AIDS………………	Yes	No	When______________	Ulcers…………………….	Yes	No	When______________
Liver Conditions………..	Yes	No	When______________	High/Low Blood Pressure…	Yes	No	When______________
Migraines…………………	Yes	No	When______________	Seizures/Epilepsy………..	Yes	No	When______________
Osteoporosis……………	Yes	No	When______________	Other______________________			
Polio……………………..	Yes	No	When______________				

Are you currently taking any medications? □ Yes □ No If yes, please list including dosage and times per day.

Medication		Medication	
______________________	Number/Each Day________	______________________	Number/Each Day__________
______________________	Number/Each Day________	______________________	Number/Each Day__________
______________________	Number/Each Day________	______________________	Number/Each Day__________

Women: Are you or were you taking birth control? □ Yes □ No When?______________________ For how long?______________

Who is your current primary doctor? Name:______________________________ Location______________________________

Do we have your permission to consult your PCP if needed in your case? □ Yes □ No Please Sign______________________________

PAST SURGICAL HISTORY

Have you ever had any surgeries including spine surgery? □ Yes □ No If yes, please give the dates and types of operation(s).

DATE	SURGERY
______________________	____
______________________	____
______________________	____
______________________	____

HISTORY OF ILLNESS IN YOUR FAMILY

Condition				Condition			
Stroke/TIA………………..	□ Yes	□ No	Relation______________	High Cholesterol………	□ Yes	□ No	Relation______________
Rheumatoid Arthritis…….	□ Yes	□ No	Relation______________	High Blood Pressure…..	□ Yes	□ No	Relation______________
Diabetes (Type I or II)…..	□ Yes	□ No	Relation______________	Heart Attack……………	□ Yes	□ No	Relation______________
Cancer……………………	□ Yes	□ No	Relation______________	Other______________________			

REVIEW OF SYSTEMS (if not previously mentioned)

Cardiovascular System Neurological System Gastrointestinal System Respiratory System
Genitourinary System Musculoskeletal System Psychiatric or Emotional

Please explain:____

SOCIAL HISTORY

Marital Status: □ Single □ Married □ Widowed □ Divorced

Tobacco Use: □ Yes □ No If yes, what type (smoking, chewing)? ____________ How often?____________ How many years? ______

What is your interest level in quitting tobacco use? __________________ If a previous tobacco user, when did you quit? ____________

Alcohol Use: □ Beer □ Wine □ Mixed drinks How many per day/per week?______________________________

Drug Use: □ Yes □ No Type and frequency:____

Creekside Chiropractic

Dr. Jennaleigh McKinley, DC ~ Dr. Ryan Baack, DC
19555 E. Parker Square Drive Suite 105
Parker, CO 80134
720.851.9878

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about the potential problems associated with chiropractic health care before consenting to treatment. This is called **Informed Consent.**

Chiropractic adjustments are the mobilization of joints with the doctor's hands or with the use of an instrument. Frequently, adjustments create a "pop" or "click" sound or sensation on the area being treated.

In this office, we may use trained staff personnel to assist the doctor with portions of your consultation, examination, x-rays, physical therapy applications, traction, massage therapy, exercise instruction, etc.

The following is a list of possible complications that can arise from an adjustment.

STROKE: Stroke is the most serious problem associated with receiving an adjustment. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The result can be a temporary or permanent dysfunction of the brain, and very rarely, death. Cervical (neck) adjustments have been associated with strokes that arise from the vertebral artery; this is because the vertebral artery is actually found inside the neck vertebrae. The type of adjustment that is related to vertebral artery stroke is called the "maximal extension-rotation" adjustment. We do not perform this type of adjustment on patients. Other types of neck adjustments may also be potentially related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA, Vol 35 No. 2, June 1993) estimate that the incident of this type of stroke is 1 per every 5,850,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

DISC HERNIATION: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both back and neck. Yet occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

SOFT TISSUE INJURY: Soft tissues primarily refer to the muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, adjustments, traction, massage, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary

treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

RIB FRACTURES: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely an adjustment will crack a rib bone; this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis on their x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

PHYSICAL THERAPY BURNS: Some of the machines we use generate heat. We also use both heat and ice and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain and in extreme cases there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

SORENESS: It is common for an adjustment, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is almost always a temporary symptom while your body is undergoing therapeutic change. It is not dangerous, but please notify your doctor if it occurs.

ACUPUNCTURE: Patients will receive information regarding all methods of treatment used in acupuncture, which involves the insertion of fine needles at specific points in the body, manual manipulation of the needles and/or electrical stimulation or application of localized heat. In addition, recommendation of herbal supplements as related to the scope of practice of oriental medicine according to Federal Legislation may be used. Mild discomfort may be experienced, but this pain is unusual. Bruising at the acupuncture point is a possibility. Due to differences in human constitution and response, it is not possible to guarantee any specific effect resulting from the acupuncture treatment. This practice of acupuncture uses disposable needles only and complies with all regulations set forth by the NCCAOM and NCCA.

OTHER PROBLEMS: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These problems or complications occur so rarely that it is not possible to anticipate and/or explain all of them in advance to treatment.

Chiropractic is a system of health care delivery, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

______________________________	______________________________
Patient's Name Printed	Today's Date
______________________________	______________________________
Patient's Signature	Parent or Guardian Signature

Creekside Chiropractic

PATIENT CONSENT

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I ______________________, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to me signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice:
   a. A text message sent to me at the phone number provided by me
   b. Emailing a reminder to the email account I have designated.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct specific health care options.
5. I understand that I have the right to request that Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care options. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to be above and contained in the Privacy Notice, then the practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____________________________________ _____________________________________

Patient's Name Printed Patient's Signature

_____________________________________ _____________________________________

Signature of Legal Representative/Parent if minor Relationship

Date Signed ___ /___ /___ Witness: ____________________________

CREEKSIDE CHIROPRACTIC

Dr. Jennaleigh McKinley, DC ~ Dr. Ryan Baack, DC

www.chiropractorinparker.com ~ **Office: 720.851.9878** ~

Have you been to a chiropractor before? **Y** **N**

Are you currently under chiropractic care? **Y** **N** Date of last adjustment: ____________

Do you suffer from?

Headaches **Y** **N** Neck Pain **Y** **N**

Back Pain **Y** **N** Other: ____

Please circle all that are of interest to you:

Weight loss Removing toxins from the home Nicotine cessation

How did you hear about us?

____

Email address:

____

Would you like to receive our monthly e-newsletter? Y N

Appointment Policy: In order to guarantee an appointment, a credit card must be on file. When you schedule an appointment with Creekside Chiropractic, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. A 24-hour or more notice will allow other patients access to timely care. Please see our Appointment Cancellation/No Show Policy below:

- Effective July 1, 2018, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hour notice** will be will be charged a **$25 fee** to the card on file.
- Any established patient who fails to show or cancels/reschedules an appointment without a 24 hour notice a **second or more** time will be charged a **$50 fee** to the card on file.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- As a courtesy, we provide e-mail or text appointment reminders for scheduled appointments. If you do not receive your reminder message, the above Policy will still remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office. You may contact Creekside Chiropractic 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message or e-mail us at Chiro80134@gmail.com. Messages left or e-mails sent within the required timeframe are acceptable.

With my signature I agree to and authorize Creekside Chiropractic to charge my credit card in accordance with the policy outlined above.

Cardholder Signature ____

Name (please print clearly) ____Date: __________________

Creekside Chiropractic

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

Our practice is dedicated to, and we are required by applicable federal and state laws to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of March 1, 2010, and will remain in effect until we replace it.

Changes to notice:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us.

Permitted uses and disclosures of health information:

1. TREATMENT, PAYMENT, HEALTH CARE OPERATIONS: You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment and healthcare operations. Examples of these activities are as follows:
    - Treatment: We may use or disclose your health information to other health care providers providing treatment to you.
    - Payment: We may use and disclose your health information to obtain payment for services we provide to you.
2. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.
3. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care.
4. MARKETING: We will not use your health information for marketing communications without your written authorization.
5. USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information

to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes.

6. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
7. LAW ENFORCEMENT/NATIONAL SECURITY: Under certain circumstances, we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances, we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal official's health information required for lawful intelligence, counterintelligence and other national security activities.
8. APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

Patient rights:

1. ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. If you request copies, we will charge you our standard copying fee for each page and postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.
2. ACCOUNTING OF CERTAIN DISCLOSURES. Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before March 1, 2010. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
3. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and health care operations purposes. Depending on the circumstances of your request we may or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.
4. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing and must explain why the information should be amended. We may deny your request under certain circumstances.
5. ELECTRONIC NOTICES. If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

19555 E. Parker Square Drive, Suite 105
Parker, CO 80134
720-851-9878
Chiro80134@gmail.com