COLORADO
CHIROPRACTIC

865 Englewood Pkwy
Englewood, CO 80110
303.795.3668

Welcome to our clinic!

Our Mission at the Colorado Chiropractic Clinic is to provide the members of our community with high quality, affordable health care in a comfortable and caring environment. We seek to provide this by offering high-quality chiropractic care as well as educating patients on how to build & maintain a higher level of health.

The purpose of today's office visit is to allow you the opportunity to discuss your conditions with the Doctor, to determine the cause of the problem, and to take the first steps towards recovery.

To ensure your first visit with us is a pleasant one, here are the procedures you can expect during the next 30 - 60 minutes with us. Please feel free to ask questions if you need assistance.

Health History	A complete understanding of your current health issues is essential to help the Doctor provide the most appropriate treatment and recommendations.
Consultation	You will meet the Doctor who will review your health history with you and determine if yours is a chiropractic case.
Examination	Standard physical, orthopedic, neurological, and chiropractic tests will be performed to determine the cause and appropriate treatment of your condition.
Treatment	This office is unique in that the first adjustment is usually given on the same day, at the discretion of the Doctor. If you would like to be treated today, your appointment may take additional time as we analyze your case.

CONFIDENTIAL HISTORY

Today's Date: _____ Birthdate: _____ Age: _____

First: _____ Last: _____ M.I. _____ SSN: _____

Address: _____ Home Phone #: _____

City _____ ZIP: _____ Work Phone #: _____

E-mail: _____ Cell Phone #: _____

Occupation: _____ Employer: _____

How did you find us?: □ Google □ Yelp □ Insurance □ Referred by: _____

Present Complaints / Conditions in order of Importance (please be specific):

Example: *Pain in lower back on right side that goes down the back of right leg to the knee. Worse when bending.*

- _____
- _____
- _____

What day did you first notice it? _____

How did it first happen? *Example*: *Bent over to tie shoe this morning, heard a pop and felt pain. Sat still for 15 min.*

_____

_____

Have you had this or a similar condition in the past? □ Yes □ No Explain: _____

_____

What treatment have you received for your condition: □ Medication □ Surgery □ Physical Therapy □ Chiropractic □ None □ Other _____

EXPERIENCE WITH CHIROPRACTIC

Have you seen a chiropractor before: □ Yes □ No

If yes, who? _____ When? _____

Reason for visits: _____ How did you respond? _____

Length of treatment: _____ X-Rays taken? _____

PERSONAL MEDICAL HISTORY

Full Name of Primary Care Physician or Family Doctor: _____

May we send our findings to your Doctor? □ Yes □ No

Have you been treated for any health condition by a Physician in the last year? □ Yes □ No

If so, for what condition? _____

List the approximate dates of any surgeries, serious illnesses, accidents, or unusual diseases you have had:

_____

Joint Replacement(s) / Date(s): _____

List all medication(s) that you have used recently (i.e., aspirin, sleeping pills, anti-depressants): _____

_____

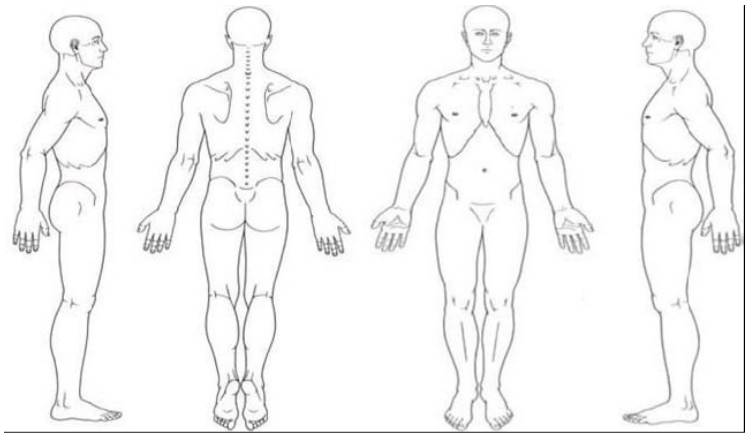
Has medication been helpful with your pain? □ Yes □ No

Date of last: Spinal X-ray: _____ Physical Exam: _____ Blood / Urine Test: _____

List all nutritional and/or vitamin supplements taken regularly: □ Multivitamin □ Fish Oil □ Probiotic □ VitaminD □ Others: _____

Do you exercise? □ Yes □ No What Activities? _____ How often? _____

Please mark specific areas of pain on the figures below:



Which of the following cause pain or are difficult?

□ Bending
□ Walking
□ Exercise
□ Sleep
□ Sitting long periods
□ Standing long periods
□ Walking stairs
□ Self-care
□ My Job - duties: _____
□ Cleaning - activities: _____
□ Recreation - activities: _____

Type of Pain: □ Local □ Sharp □ Tingling □ Traveling □ Dull □ Numb

What is your TYPICAL or AVERAGE pain?

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

What is your level of pain AT ITS WORST?

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms?
□ Constantly (76-100% of the day)
□ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day)
□ Intermittently (0-25% of the day)

How are your symptoms changing?
□ Getting Better
□ Not Changing
□ Getting Worse

When do you notice them most?
□ Morning
□ Afternoon
□ Evening
□ In Bed

For each of the conditions listed below, place a check in the past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the present column.

Past	*Present*	
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbance
○	○	Dizziness

Past	*Present*	
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	*Present*	
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Tobacco Prod.
○	○	Drug/Alcohol Dependency
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS

Females Only

○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy

Other Health Problems/Issues

○	○	_____
○	○	_____
○	○	_____

Patient Initials: _____

Colorado Chiropractic Clinic Financial Agreement

Our goal is to clarify the financial aspect of your care so we can direct all of our attention to helping you get well.

- **Participating Insurance Plans**

Insurance policies are an arrangement between the insured and the insurance company. If our office processes and submits a claim on your behalf, we will charge for all services that are provided. You will be responsible for any expenses the insurance carrier does not meet and/or contract allows. In general, we expect payment of deductibles, co-payments, and co-insurance at the time of each visit.

This office will resubmit a claim one time. Claims are filed with your insurance company as a courtesy and we are not responsible for insurances misquoting coverage or denying payment. If coverage problems arise, you will be expected to contact your insurance company, adjustor, or agent. Any denied or disputed claims will be treated as non-covered services and you will be expected to pay such charges in a timely manner.

- **Non-participating Insurance Plans**

If you have an insurance plan that we do not participate with, we will submit claims at your request, however we do ask for payment in full at the time of service. At your request, we will continue to submit your claims for you, but in the case that your insurance company denies payment, you will be responsible for any unpaid balance. If you prefer, we will provide you with an itemized receipt that has necessary information for submission to your insurance company.

- **No Insurance Coverage**

Our office offers a reduced rate at the time of service for patients without insurance benefits. We also offer pre-paid packages at a discount for patients who have completed their initial visit. It is our policy in this office to maintain your account on a current basis. Charges for treatment are due at the time service is provided unless other arrangements have been made with our office. We accept cash, checks, MasterCard, Visa, and debit cards.

Signature: _____ Date:_____

Colorado Chiropractic Clinic Authorization Agreement

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, chiropractic care or any clinic services that he/she deems necessary in my case. I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services, insurance companies, workers compensation carriers, or the patient's employer.

Signature of Patient:_____ Date:_____

Responsible Party (Guardian) Signature:_____ Date:_____

Colorado Chiropractic Clinic, P.C.

Consent to Examination and Diagnostic Procedures Patient Initials:_____

I do hereby authorize the Doctors of Colorado Chiropractic Clinic, P.C. and/or their associates, or assistants to perform upon me (or the patient below, for whom I'm legally responsible) examination and diagnostic procedures arising from any current, past, or unforeseen condition(s), which Colorado Chiropractic Clinic, P.C. may consider necessary or advisable in the course of my health care. I understand that it is my responsibility to fully disclose my prior health history and all current issues to the doctor so that an informed diagnosis can be formed and any possible contraindications or risks can be assessed. I understand and agree that the Doctors of Chiropractic and their associates or assistants, have the right to refuse to accept me as a patient at any time before treatment begins. The consultation (taking of a history) and conducting of a physical examination are not considered treatment, but are part of the information-gathering process so that the doctor can determine whether to accept me as a patient.

HIPAA Privacy Policy Patient Initials:_____

With my signature below, I give consent for Colorado Chiropractic Clinic, P.C. to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations. I have reviewed the Privacy Policy of this Practice before signing this consent. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge, simply by asking for one.

- I have the right to request restriction (in writing) on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operations. While Colorado Chiropractic Clinic, P.C. isn't required to agree to restrictions, Colorado Chiropractic Clinic, P.C. is bound to honor and abide by any such restrictions to which it has agreed.
- I have the right to revoke this consent (in writing). Revocations will be honored from the time written and delivered to the Colorado Chiropractic Clinic, P.C. office, but revocation can't affect any action already taken in reliance upon the consent given.
- I realize that my personal information that is protected by federal privacy law may be used and/or disclosed with my consent, and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

Informed Consent to Chiropractic Adjustments & Care Patient Initials:_____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy and diagnostic tests on me (or the patient below, for whom I am legally responsible) by the Doctors of Chiropractic at Colorado Chiropractic Clinic, P.C. and/or their assistants or associates who now, or in the future treat me while affiliated at said office. I have had an opportunity to discuss with the Doctor of Chiropractic adjustments and other procedures. I understand that there are no guaranteed results in conventional medicine, nor in chiropractic treatments. I've been informed and understand that as in the practice of medicine, there are some potential risks associated with chiropractic treatments. Most patients do not experience any side effects or adverse events with chiropractic adjustments. These risks include but are not limited to soreness, sprain/strains of soft tissue, fractures, or dislocations. Spondylolisthesis & disc herniations can be present even in non-symptomatic areas. These can be helped by chiropractic but there is also a risk of aggravation of these tissues. These events are rare enough that there are no available statistics to quantify their probability. There are also risks associated with active and passive rehabilitation such as soft tissue irritation, sprain/strains, and burns. These risks are heightened with pre-existing conditions such as sunburns. It was once estimated that the incidence of stroke could occur in every three million adjustments. More recent medical research has shown no increased risk of stroke from chiropractic care compared to regular medical care. I understand I have the option to request non-manual adjustments. Research does not support taking x-rays for every patient, since the costs and risks outweigh benefits in many cases. X-rays will be taken at the doctor's discretion. I do not expect the doctors to anticipate and explain all risks and complications. I wish to rely on the doctors to exercise their best judgment during the course of the procedure that the doctor feels is in my best interest.

The Practice may communicate confidential information to me, including any invoices for services, at the address/phone number/fax number/email address I have listed on my intake form

I have read, or have had read to me, the above consents. I also have had the opportunity to ask questions about their content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of my treatment for my present condition and for any future condition(s) for which I request treatment. I further permit copies of this authorization to be used in place of the original.

Print Patient Name	**Patient Signature**	**Date**
Print Guardian's Name (for minor patient)	Guardian's Signature	Date