# LIFETIME
## HEALTH AND WELLNESS

**Randy B Snyder** DC, DACBSP, C.Ac, Fiaca **Courtney R. Gilmer** DC •
8155 W.94th Avenue• Westminster, CO 80021 • (303) 423-4610- **Fax** (303)431-8658

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**Your Name:** _____ **Today's Date:** _____

**Date of Birth:** ____ / _____ / _____ **Age:** _____ □ **Female** □ **Male** □ **Prefer Not To Answer**

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**# Social Security:** _____ **Telephone:** _____ □ **Cellular** □ **Home**

**Alternative Telephone:** _____ **Email:** _____

**Marital Status:** □**Single** □**Married** □**Divorced** □**Widowed**

**Spouse Name:** _____

**Who Referred To Our Office:** _____

**nsurance Company:** _____

**Policy # / Group:** _____ **Emergency Contact** (Name and Last name):_____

**Telephone:** _____ **Patient Relationship:** _____

**Please Indicate Doctor Preference:** □ **Dr. Snyder** □ **Dr. Gilmer**

**Your Employer:** _____ **City:** _____

**Your Occupation:** _____

**Type of Work:** □Office □Manual □Travel □Homemaker

**Work Requirements:** □Lifting □Bending □Back Loaded □ Lifting Children
□ Data Entry □ Cradling Telephone □ Sitting Prolonged □ Prolonged Standing

**Primary Provider Name:** _____ **Telephone:** _____

**Which of the Following Statements Describe Better Your Attitude About Your Healthcare and Your Health:** (Mark with an **X** )

□ I seek medical attention only when it is totally necessary

□ My primary health goal is that symptom-free star. I take care of my symptoms when they are minor.

□ I am inclined to prevent future health problems through my lifestyle choices such as exercise, nutrition, and other health abuses.

## *Tell Us What Is Bothering You*

To give the doctor a clear understanding of your case, we would like you to answer a few simple questions. Please be as specific as possible in the questions and body diagrams. If you have any questions about any part of this form do not hesitate to ask for help, especially from the doctor.

**What Health Problem Brings You To Our Office:** _____

**When did the problem begin? (If you have had this problem for a long time, from the date when you finally decided you were in care):**

_____

**Is it due to a recent accident or injury:** □Yes □No □Do not know

**If "Yes", was it?** □Car □Work □Other (Describe):_____

**Date of Accident:** _____ **Time:** _____ □AM □ PM

**Have your injuries been reported?** □ Yes □ No **If "Yes" to whom?**_____

**Have you seen another doctor or been treated as a result of this condition / accident?** □ Yes □ No

**Names and Specialties:** _____

**What did the other doctor(s) / Specialist(s) do:** □ Examination □X-ray □Traction □Injections □ Physiotherapy (how long?): □Other

**What is the main area of complaint?** (Ex. neck pain, headache, lower back, arms / legs pain):

_____

**How long has it been since you felt good?** _____
**How long have you been in the care of a doctor?** _____
**Are you still under a doctor's care?** □ Yes □ No

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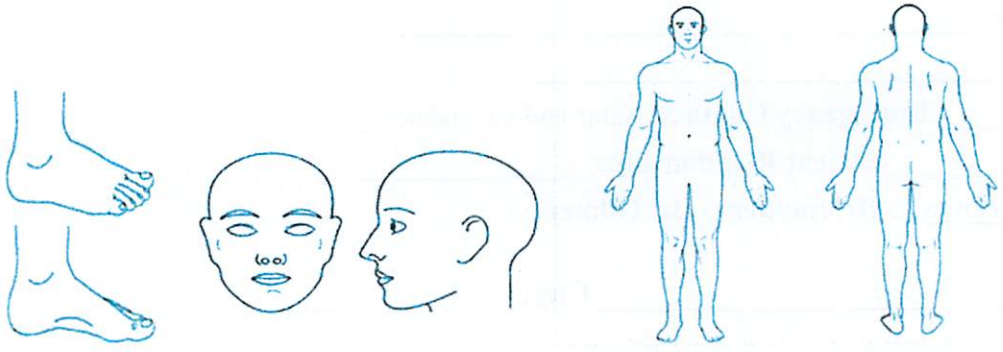
**Please mark the area of your main discomfort in the following diagram.** If you have pain that goes up or down to another part of the body please indicate where you are traveling.

*FOOT* *HEAD* **RIGHT** **LEFT**



**FRONT** **BACK**

**Describe your pain:** □Sharp □ Dull Ache □ Deep Stabbing □ Burning □ Other
**Intensity Of Pain**_____ 0-10 (10 being the highest) **Frequency Of Pain:** _____(# times / week)

**Mark the following symptoms related to your condition:**

□ Headache
□ Insomnia
□ Diarrhea
□ Chest Pain
□ Visual Fatigue
□ Paleness
□ Lack of Breathing
□ Nausea or Vomiting
□ Nasal Problem
□ Extremely Nervous (a)
□ Difficulty Sitting Remained
□ Tiredness on Head/ Shoulders
□ Neck Pain
□ Tension
□ Fainting
□ Dizziness
□ Pain behind the Eyes
□ Palpitations
□Cold Hands
□Leg Problems
□ Stress Fatigue
□ Digestive Disorder
□ Head seems heavy
□ Constipation
□ Double Vision
□ Tremors
□ Pain in Joints
□Cold Feet
□ Excessive Sweat
□ Muscle jerking
□ Depression
□ Irritability
□Anxiety

□Stiffness or back pain in: □Upper □Mid □Lower
□Radiating Pain to: □Arms □Buttocks □Legs □Feet

□Movement Restriction: □Neck (Left / Right) □Shoulders (Left / Right) □Arms (Left / Right)

□Numbness/Tingling in: □Neck (Left / Right) □Shoulder (Left / Right) □Arms (Left / Right) □Hips (Left / Right) □Fingers (Left / Right) □Legs (Left / Right)

□Needles/Pins sensation: □Neck (Left / Right) □Shoulder (Left / Right) □Arms (Left / Right) □Hips (Left / Right) □Fingers (Left / Right) □Legs (Left / Right)

**Any other condition not specified:** _____

**Which factors make your complaint worse:**

□Sitting for long periods □Standing for long periods □Walking □Driving
□Lifting: □ Light □Moderate □Heavy □Repetitive
□Twisting: □Light □ Moderate □Heavy □Repetitive
□Standing: □Light □ Moderate □Heavy □Repetitive
□Other Activities (please describe): _____

**Mark any of the following that helps or better your complaint:**
□Ice □Heat □Stretch / Exercise □Rest □Massage □Medication (indicate): _____
□ Other (Specify): _____

**Does your pain seem to be worse at any of the following times of day?**
□Worse in morning □Worse in afternoon □Worse at night □The pain wakes up □Worsens with activity
□Constant, no relief □ Other (specify):

**Are there activities you cannot do because of this condition?**
□ Work (for how long) □ Clean the home □ Drive □ Pick up things □ Play a sport / activity
□ Other (specify):
**Your pain seems to be:** □Improving □Worsening □Staying the same

_____

**Have you had the same or similar condition before?** □ Yes □ No

**Other health problems that concern you:** _____
_____

## History: (This Section Must Be Completed)

| | Circle one (1) | DATES: | DESCRIBE: |
|---|---|---|---|
| **Previous Car Accident:** | YES NO | | |
| **Serious Fall:** | YES NO | | |
| **Hospitalizations:** | YES NO | | |
| **Surgery:** | YES NO | | |
| **Disorders:** | YES NO | | |
| **Doctor Visits Recent:** | YES NO | | |

**Date of last:** Physical Exam _____ Spinal X-ray_____ Spinal Exam_____
Chest X-rays_____ Blood Test_____ Dental X-rays_____ Urine Exam_____

**You take:** □ Nerve pills □ Muscle relaxants □ Analgesics □ Tranquilizers
□ Insulin □ Birth Control □ Other: _____

**Take vitamins and / or minerals:** □ Yes □ No which (list): _____

**Habits (please say the amount):** □ Tobacco ___ (packages / day) □ Alcohol ____ (drinks / day)
□ Caffeine (coffee / tea / soda) _____ □ Exercise out of work _____ (hours / week)
□ Sleep ____ (hours / night) Do you sleep on: □Back □Side □Stomach
□ Do you use a bed board? □ Yes □ No Is your bed comfortable? □ Yes □ No

**Do you wear:** □Heel lift □Sole lift □Insoles □Arch support □Back support □Prescribed orthotics

**Mark the diseases you have had:**

□ AIDS / HIV
□ Hepatitis □A □B □C
□ Smallpox
□ Diabetes
□ Mumps
□ Polio
□ Heart Disease
□ Rheumatic Fever
□ Chickenpox
□ Multiple Sclerosis
□ Whooping Cough
□ Epilepsy
□Rheumatic Arthritis
□ Cancer / Tumors
□ Measles
□ Typhoid Fever
□ Eczema
□ Other: _____
□ Anemia
□ Malaria
□ Tuberculosis
□ Diphtheria
□ Pneumonia

**Are you aware of any diseases that run your family: □ Yes □ No**
**Please describe:** _____
_____

**Do any family members have similar health problems: □ Yes □ No (Please describe):**
_____
_____

# For Women Only:

**Date of Last Normal Period: _____ Menstrual cycle: _____ days**

**First period at the age of: _____ Date of last visit to the gynecologist: _____**

**Is there a possibility of pregnancy? □Yes □ No**

## Indicate all that apply:

□ Cycles irregular
□ Premenstrual Stress
□ Pain During
□ Cramps or Back Pain
□ Excessive Flow
□ Other Menstrual Symptoms
□ Menopause Symptoms
□ Conjugated Breasts, Breast Lumps

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# Consent for the Purpose of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by C.E.O. Westminster for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or for carrying out health care operations. I understand that the analysis, diagnosis or treatment of me by C.E.O. Westminster may be subject to my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. C.E.O. Westminster s not required to agree to the restrictions they I may request. However, if C.E.O. Westminster agrees to a restriction that I request, the restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that C.E.O. Westminster has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me, created or received by my doctor, another health care provider, a health plan, my employer or a health care compensation center. This protected health information relates to my past, present or future health or physical or mental condition and identifies me, or there is a reasonable basis to believe that you can identify me.

I have been provided a copy of the Notice of Privacy Practices of CEO Westminster. I understand that I have the legal right to review the Notice of Privacy Practices of CEO Westminster before signing this consent and we encourage you to read it in its entirety. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations in our clinic. The Notice of Privacy Practices for CEO Westminster is also posted in the waiting room at 8155 W. 94th Ave Broomfield, CO 80021.

The Notice of Privacy Practices for CEO Westminster is subject to change. I may obtain a revised notice of privacy practices by calling our clinic and requesting that a copy be sent by mail or requesting one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Authority of Personal Representative

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# ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of the Notice of Privacy Practices from this office. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in the provision of my treatment.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

_____

☐ **Please check here to authorize our office to release records to your PCP**

**For Official Use Only**

**We attempted to obtain written Acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:**

**□ Individual refused to sign**

**□ Communication barriers prohibited obtaining the Acknowledgment**

**□ An emergency situation prevented from obtaining Acknowledgment**

**□ Other (Please Specify)**_____

_____

**Staff Signature** **Date**

# OFFICE POLICIES

***Please read our policies and acknowledge by initialing next to each statement and sign the bottom***

_____ All payments are **DUE AT TIME OF SERVICE** including co-pays, co-insurance, deductible amounts, and/or non-covered procedures. If payment is not made at time of service, a **$10 billing fee** will be applied to your balance.

_____ Insurance cards presented are current and accurate. We will contact your insurance to verify benefits, however, this is not a guarantee of coverage or payment. Ultimately, it is the patient's responsibility to know insurance coverage. We know your claim is processed once we receive payment and an explanation of benefits (EOB).

_____ Insurance companies have 45 days to approve or deny a claim. In some cases, this may take longer if extra information is requested.

_____ For any balance remaining after insurance has paid, you will be mailed a statement. Please contact your insurance company if you feel insurance has paid incorrectly.

_____ If bill is not paid within 30 days of receiving statement or billing department is not contacted, a **$15 billing fee** will be applied each billing thereafter.

_____ We understand there are times where you are unable to keep an appointment. We request 24-hour notice for cancelling an appointment. A **$20 fee** may be assessed if we are not contacted in time. You may leave a voicemail if the office is closed.

_____ In accordance with the State of Colorado statutes, no doctor shall engage in a personal relationship with any patient outside the parameters of normal conduct of doctor-patient interaction.

## *AUTHORIZATION TO RELEASE INFORMATION*

I hereby authorize CEO Westminster Inc. to release any appropriate information concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release CEO Westminster Inc. of any consequences thereof. I authorize my insurance and/or attorney to pay by check made out and directly mailed to CEO Westminster Inc. Further, I agree to pay CEO Westminster Inc. the difference, if any, between the total amount of charges and the amount paid by the insurance carried and/or attorney. A photocopy of this document will be deemed as valid and binding on all parties involved.

I have read and have full understanding of all policies and HIPPA agreement of Lifetime Health & Wellness.

Patient Name: _____

Patient Signature: _____ Date: _____

**OR**

Legal Guardian Signature: _____ Date: _____

Relationship to Patient: _____ Witness Initials: _____

To the patient: Please read the document in its entirety prior to signing it. It is important that you understand the information explained below. If you have any questions please ask before you sign.

**Nature of Chiropractic Treatment**
Prior to beginning treatment, you will be given a physical examination that can include taking vital signs, range of motion testing, muscle strength testing, palpation, orthopedic testing, and neurological testing. Once your condition has been diagnosed, the primary method of treatment will be spinal manipulation, also known as spinal adjustment. An adjustment is a quick, precise movement of the spine over a short distance. Adjustments are usually performed by hand but may be performed by handguided mechanical instruments. In addition to spinal manipulation, treatment can also involve other forms of therapy including electrical stimulation, traction, cold packs, hydrotherapy, infrared heat, exercise, acupuncture, dry needling, massage, A.R.T., cranial therapy, rapid release, and nutritional supplements.

**Risks of Chiropractic Treatment**
All health care procedures carry some degree of risk. The most common side effect of spinal manipulation is short-term muscle soreness. More serious side effects can include bone fractures, muscle strain, ligament sprain, joint dislocation and injury to the discs, nerves or spinal cord. Some manipulations of the upper spine have been associated with injury to the arteries in the neck, which could cause or contribute to stoke. However, documented cases are exceedingly rare, and it has been estimated by researchers that the probability of a spinal adjustment causing a stroke is one in several million. Compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.

**Treatment Options Other Than Chiropractic**
Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics;
- Medical care and prescription drugs such as muscle relaxers, pain killers and drugs to reduce inflammation;
- Surgery;
- Remaining untreated.
- Physical therapy

If you decide to pursue other treatment options, you should discuss the risks and benefits with your medical physician. Remaining untreated carries its own risks and may allow the formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce mobility and induce chronic pain cycles.

*I have read above the explanation and risks of Chiropractic treatment and possible therapies. By signing below, I state that I have weighted the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.*

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Date