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PATIENT INFORMATION

Today's Date _____

Welcome to our practice. Please answer the following questions. This will give the doctor valuable information needed to help you. Please be as accurate and complete as possible.

First Name: _____ Last Name: _____

Gender: ☐ M ☐ F Date of Birth: ____ /____/_____ Age: _____ Height: ____ ft. ____ in. Weight: _____ lbs.

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

Phone: _____ ☐ H ☐ C ☐ W 2nd Phone: _____ ☐ H ☐ C ☐ W

Email: _____ Preferred method of communication: ☐ Phone ☐ Text ☐ Email

Occupation: _____ Employer: _____ Work Phone: _____

Work Address: _____ City: _____ State: _____ Zip: _____

City _____ State _____ Zip Code _____

Marital Status: __ M __ S __ W __ D Spouse's Name: _____ # of Children: _____

Emergency Contact: _____ Phone: _____ ☐ H ☐ C ☐ W

Name and Address of Family Physician: _____

_____

Are you Medicare Eligible? ☐ Yes ☐ No

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)? ☐ Yes ☐ No

How did you hear about The Health and Wellness Center? _____

CURRENT HEALTH CONDITION

Reason for today's visit (check all that apply):

☐ Pain ☐ Poor Posture ☐ Automobile Accident Injury ☐ Problems with Allergies ☐ Discomfort ☐ Stiffness

☐ Maintenance Care ☐ Recent Injury ☐ Previous Injury ☐ Other _____

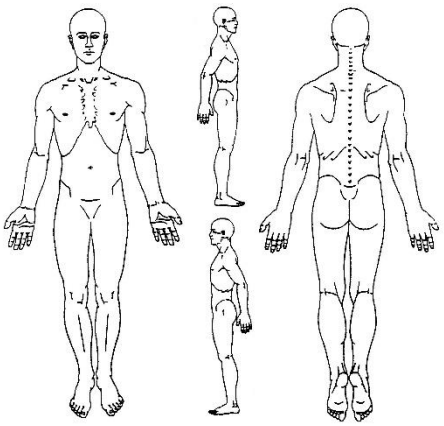
Describe what happened/what's going on: _____

When did your complaint(s) first begin? _____ Today, it is: ☐ Same ☐ Better ☐ Worse

Explain what helps and/or worsens the condition: _____

	Where is/are your area(s) of complaint today? Check all that apply	Rate pain & discomfort between 1-10 1 = minimal 10 = severe	Check off the type of Complaint: Radiating	Sharp	Dull	Tingling	Numbness	Burning	Inflammation/ swollen	Frequency: Constant	Intermittent
	Headache/Migraine										
	Neck										
	Shoulder(s)										
	Arm(s)										
	Elbow(s)										
	Wrist(s)										
	Upper Back										
	Middle Back										
	Lower Back										
	Hip(s)										
	Sciatica										
	Knee(s)										
	Ankle(s)										
	Rib(s)										
	Other:										

Use the figure below to place an "X" on any specific area(s) where you are experiencing pain, discomfort or limited range of motion.



Have you experienced this/these complaint(s) before? ☐ Yes ☐ No If yes, when? _____

Are you pregnant? ☐ Yes ☐ No ☐ N/A if yes, how many weeks: _____

Other doctors seen for this Complaint: _____ Their opinion/diagnosis? _____

Current prescriptions or Over-The-Counter medications? _____

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PAST HEALTH HISTORY

Major surgeries/operations: ☐ Head ☐ Neck/Throat ☐ Chest/Heart/Lung ☐ Back ☐ Abdominal
Other: _____

Previous fractures or broken bones: ☐ Yes ☐ No What? _____

Previous fall or accidents: ☐ Yes ☐ No When? _____

Previous hospitalization: ☐ Yes ☐ No When? _____

Previous Chiropractic care: ☐ Yes ☐ No Doctor? _____

Has anyone else in your family had a similar problem? ☐ Yes ☐ No Who? _____

Do you participate in any sports or exercise programs? ☐ Yes ☐ No Describe: _____

Were treated by a physician for any condition in the last 12 months? ☐ Yes ☐ No Condition? _____

Are you allergic to any medication? ☐ Yes ☐ No What kind? _____

Check any of the following that applies to you:

				INTAKE or USE
☐ AIDS/HIV	☐ Cancer	☐ Gout	☐ High Blood Pressure	☐ Alcohol
☐ Allergies	☐ Chronic Fatigue	☐ Headaches	☐ Migraines	☐ Recreational Drugs
☐ Arthritis	☐ Diabetes – I or II	☐ Heart Disease	☐ Pacemaker	☐ Tobacco
☐ Asthma	☐ Epilepsy/Seizure	☐ Hernia	☐ Stroke	☐ Pain Relievers
☐ Autoimmunity	☐ Fibromyalgia	☐ Hepatitis – A or B or C	☐ Tumors	☐ Prescribed Drugs
☐ Bowel/Bladder	☐ Frequent Illnesses	☐ Other: _____		

Check any problem that you have had in the past 6 months:

Muscles-Skeleton Movement
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Problems Walking
- ☐ Difficulty Chewing - TMJ
- ☐ General Stiffness

Nerve System
- ☐ Headaches
- ☐ Nervousness
- ☐ Numbness/Tingling
- ☐ Muscular Weakness
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Depression
- ☐ Fainting
- ☐ Convulsions/Seizures
- ☐ Cold Hands Feet
- ☐ Stress
- ☐ Shaking/Tremors

Circulation-Breathing
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heart Rate
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Stroke

Digestion-Elimination
- ☐ Poor Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Weight Loss/Gain
- ☐ Gas/Bloating
- ☐ Heartburn
- ☐ Change in Stools

Eye-Ear-Nose-Throat
- ☐ Visual Disturbances
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Difficulty Hearing
- ☐ Stuffy Nose
- ☐ Sinus Drainage/Pain
- ☐ Pain – Forehead or Face

Urinary-Genitals
- ☐ Pain with Urination
- ☐ Infrequent Urination
- ☐ Frequent Urination
- ☐ Weak Urine Stream
- ☐ Loss of Bladder Control
- ☐ Pain in Genitals

Female Only
- ☐ Menstrual Pain/Irregularity
- ☐ Low Back Pain w/ Periods
- ☐ Breast Pain/Lumps

Family Health History

☐ Cancer ☐ Tumors ☐ Stroke ☐ Seizures ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease

_____ _____

(Patient or Legal Guardian Signature (Date)

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PATIENT ACTIVITY ASSESSMENT FORM

Name: _____ Today's Date _____/_____/_____

Occupation: _____ Age: _____

The purpose of this form is to assist the doctor in better understanding your daily activities, your ability to perform them, and how they relate to the function of your body. Your answers will provide important information in establishing a customized plan of care designed to place you on the path towards attaining and maintaining your health care goals.

STANDING OR SITTING

Do you primarily stand or sit at work: ☐ Stand ☐ Sit

Approximately how many hours per week:

☐ 0-20 hours ☐ 20-40 hours ☐ 40+

Are those hours primarily spent:

On the phone:

☐ Cell ☐ Desktop phone ☐ Headset ☐ No headset

Typing at a keyboard:

☐ Laptop ☐ Desktop computer

What is your most common posture:

☐ Sitting upright ☐ Slouched ☐ Crossed legs ☐ Stand

Does your work require you to:

☐ Bend ☐ Twist ☐ Lift ☐ Carry ☐ N/A

What type of shoes to you wear on a regular basis:

☐ Dress ☐ Heels ☐ Running ☐ Boots ☐ Athletic

☐ Sandals ☐ Other _____

Do you wear orthotics: ☐ Yes ☐ No

Do you spend most of your workday on a computer?

☐ Yes ☐ No

How hours a day are spent in front of a TV, a game console or computer monitor? ☐ 0-3 ☐ 4-6 ☐ > 6 hs

Do you experience headaches during the day/after the work day from staring at the screen? ☐ Yes ☐ No

Do you have a sensitivity to light? ☐ Yes ☐ No

Do you clench your jaw during the day or night?

SLEEPING

What type of bed do you sleep in:

☐ Memory foam ☐ Adjustable firmness ☐ Inner spring

☐ Other: _____

How many hours of sleep do you get per night?

☐ 8 hrs or less ☐ More than 8 hrs

What position do you sleep in?

☐ Back ☐ Stomach ☐ Side ☐ All

Do you regularly wake with back stiffness: ☐ Yes ☐ No

Do you regularly wake with neck stiffness: ☐ Yes ☐ No

Do you feel rested when you wake up? ☐ Yes ☐ No

BODY STRESSORS

Daily activities that require you to lift and/or carry objects:

☐ Yes ☐ No

If yes, how often:

☐ Occasionally ☐ Frequently ☐ Constant

If yes, approximately, how heavy:

☐ 10 lbs or less ☐ 10-30 lbs ☐ More than 30 lbs

Do you exercise: ☐ Yes ☐ No

If yes, approximately, how many days per week:

☐ 0-1 day(s) ☐ 1-3 days ☐ 3+ days

Type(s) of exercise:

Weight training:

☐ Free weights ☐ Machines ☐ Other _____

Cardio training:

☐ Elliptical ☐ Treadmill ☐ Running

☐ Other _____

Do you participate in sports: ☐ Yes ☐ No

If yes, please indicate all that apply:

☐ Football ☐ Skiing ☐ Basketball

☐ Tennis ☐ Golf ☐ Body Building

☐ Dancing ☐ Yoga ☐ Walking/Hiking

☐ Other _____

Do you have children at home? ☐ Yes ☐ No

If yes, how many? ☐ 1 ☐ 2-3 ☐ more than 3

Do any require you to carry them? ☐ Yes ☐ No

ACTIVITY ASSESSMENT

Did You Know: the absence of pain is not an indication of health ☐ Yes ☐ No

Did You Know: pain has a cause and many times, it begins in the spine? ☐ Yes ☐ No

Did You Know: your daily activities can cause joint pain? ☐ Yes ☐ No

Did You Know: your daily activities can Cause spinal dysfunction? ☐ Yes ☐ No

Did You Know: poor posture leads to joint deterioration and muscle imbalance? ☐ Yes ☐ No

Did You Know: poor posture can cause decreased joint motion and function? ☐ Yes ☐ No

Did You Know: poor posture can affect your ability to enjoy a healthy, active lifestyle? ☐ Yes ☐ No

Did You Know: a chiropractic care program emphasizing posture can improve lifestyle? ☐ Yes ☐ No

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TERMS OF ACCEPTANCE

EXPLANATION OF SERVICES

"Good" posture is synonymous with fluid bodily movements, supple balance against gravity, and efficient muscle utilization. "Bad" posture on the other hand is associated with dysfunctional movement patterns, weak balance -ability, and distorted body alignment. The primary determinant of posture is our lifestyle habits.

Routine activities regularly cause subluxations of the spine and posture collapse. These subluxations, otherwise known as joint dysfunctions or fixations, create interference with the transmission of proper neuro-electrical communication through the spine and extremities. This can cause abnormal spine loads, decreased joint motion, pain, discomfort and/or a lessening of the body's ability to function properly and, over time, pathology. Chiropractic and posture neurology focuses on conditions stemming from restricted joint motion, mainly of the spine and related nervous system, and the effects of these disorders on general health.

Our primary focus is providing patients with a pathway towards better health through ongoing posture awareness and rehabilitation through chiropractic treatment consisting of maintenance and preventative care. Our number one concern is the health and safety of the people we serve. Therefore, we only accept those patients determined to have the potential to benefit from our care. To receive the most from the services provided, it is important to better understand what we do and don't do:

WHAT WE DO

- We provide the public with a unique and affordable portal of entry to wellness through routine chiropractic care and the rehabilitation of the posture system often resulting in better posture and function, improved joint motion, and a healthier, more active lifestyle.
- We accomplish our goal through the gentle application of a targeted movement where and when indicated by licensed Doctor(s) of Chiropractic to improve motion of the body's spinal column and extremities (this is commonly referred to as an adjustment or manual manipulation) and specific brain-based therapies to support posture fitness.

WHAT WE DON'T DO / LIMITATION OF SERVICES

- We do not offer to treat any disease or condition other than joint dysfunctions associated with the spine and extremities, postural collapse and dysfunction associated with the neuromusculoskeletal system and allergies and sensitivities as addressed through Nambudripad's Allergy Elimination Technique (NAET).
- We do not accept or bill insurance, Medicare, and/or any third-party carrier for payment, except in the case of personal injury cases as the result of automobile accidents.
- We do not have extensive diagnostic or on-site x-ray equipment or provide invasive testing/treatment or administer the physiotherapies massage, electrical muscle stimulation or ultrasound.
- Our services are limited to the reparative/preventative effects of routine care by improving joint mobility and function in the spine and extremities, improving postural fitness, and NAET.
- In the doctor's professional opinion, should patient need x-rays, additional diagnostic testing, or other forms of health care services, they will be referred to an appropriate provider or facility when indicated.
- Nambudripad's Allergy Elimination Technique (NAET) and Muscle Response Testing (MRT) are not Chiropractic services and, as such, are considered "unproven" by the Chiropractic Board of Colorado.

FINANCIAL RESPONSIBILITY

At the patient's discretion, payment options are available after a Doctor of Chiropractic has determined that chiropractic care is appropriate and has established a treatment plan.

All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them. All patients further understand and agree that we will not submit any billing data or related claim(s) for, or on, their behalf to any private insurance program, Medicare or an Secondary Medicare Insurance Program carrier with whom they have insurance coverage.

I, _____ have read and fully understand the above statements.
(Patient Printed Name)

_____ _____
(Patient Signature) (Date)

CONSENT TO EVALUATE AND TREAT A MINOR CHILD

I, _____ of _____ have read
(Parent or Legal Guardian) (Child/(ren) Name)

and fully understand the terms of acceptance and hereby grant permission for my child(ren) to receive chiropractic care.

_____ _____
(Patient or Legal Guardian Signature) (Date)

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INFORMED CONSENT

INFORMED CONSENT TO CHIROPRACTIC CARE

Every musculoskeletal problem is, at some level, a neurologic problem. We provide adjustments or manual manipulations for the gentle application of a targeted movement where and when indicated by a licensed Doctor(s) of Chiropractic to improve motion of the body's spinal column and extremities.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Routine chiropractic treatment can result in better function, improved joint motion, and the healthier, more active lifestyle.

However, there are some risks associated with chiropractic adjustments, including, but not limited to the possibility of sprains, dislocations and fractures. In addition:

1) While rare, some patients may experience short-term aggravation of symptoms, rib fractures or muscle and ligament sprains or strains as a result of manual therapy techniques.
2) There are reported cases of stroke associated with neck movements including adjustments of the upper cervical spine. Current medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because a stroke may cause serious neurological impairment and resulting injuries including paralysis.
3) There are reported cases of disc injuries following cervical and lumbar spinal adjustments or chiropractic treatment.

The risk of injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same conditions.

Common alternatives to adjustments and manipulations include medications, physical therapy, other medical treatments and surgery provided by physicians and surgeons.

By signing this Informed Consent, I acknowledge that I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments), the benefits, risks and alternatives to chiropractic treatment.

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care received from The Health and Wellness Center.

Dated this _____ day of _____, 20 _____

_____
(Patient Printed Name)

_____ _____
(Patient or Legal Guardian Signature) (Date)

_____ _____
(Witness/Employee Signature) (Date)