



ChiroCare

Your Natural Healthcare Choice

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PERSONAL INFORMATION

Name _____ What do you prefer to be called? _____ Date _____

Address _____ City _____ State _____

Zip Code _____ Email address _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Age _____ Sex _____ Social Security Number _____ Are you a student? _____ (Full or Part time)
Circle one

Date of Birth _____ Type of Work _____ Employer _____

Check One: Married _____ Single _____ Name of Spouse _____ Work Phone # _____

In case of emergency contact: Name _____ Phone # _____

Who is your personal physician/PCP? _____ Phone# _____

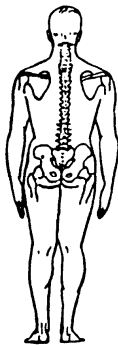
May we send correspondence to your personal physician? yes _____ no _____

Whom may we thank for referring you to our office? _____

CURRENT HEALTH CONDITION/PROBLEM

Please complete this form entirely. All of the information is important in helping the Doctor understand your condition.

Please mark the location of your pain/problem below.



Please describe your condition. Include what your symptoms feel like and how often they bother you (i.e. dull, tight, daily, etc.).

Please check any symptoms or qualities that apply in your condition:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Heavy Head | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Cold Hands |
| <input type="checkbox"/> Problems Sleeping | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Low Energy | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Jaw Pain |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Jaw Clicking/Popping |

- When was the first time you were aware of this problem/episode? _____
- How did this condition start? What caused it? _____
- Have you ever had this problem or a similar problem before? If YES, please explain. _____
- Do you have any pain/numbness/tingling/weakness in your arms or legs? _____
- When your symptoms are at their **WORST**, please rate the **SEVERITY** (1 being minimal, 10 being extreme):

1	2	3	4	5	6	7	8	9	10
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- What aggravates your condition? (Activities, Positions, Movements, Other) _____
- What improves your condition? (Ice, Heat, Sitting, Standing, Rest, Medication, Other) _____
- Does your condition vary depending on the time of day? If YES, please explain. _____
- Overall, has your condition been getting better, worse or staying the same? _____
- **How** has this condition interfered with or affected your:
 - Daily Activities? _____
 - Work Duties? _____
 - Recreational Activities? _____
 - Sleep Patterns? _____
- Are you pregnant? _____ YES _____ NO
- Please list any prescription medications, over-the-counter remedies or nutritional supplements that you are currently taking: _____
- Have you received **ANY TREATMENT** for this condition? _____ YES _____ NO
If YES, please describe when, what treatment was rendered and what the results were: _____
- Have you **EVER** consulted a Chiropractor in the past? _____ YES _____ NO
Name: _____ Dates consulted: _____
For what problem: _____

People choose chiropractic care for a number of reasons. How long you decide to benefit from chiropractic care is always up to you. Please check the type of care you desire so that we can meet your needs whenever possible.

_____ Temporary Relief _____ Lasting Correction _____ Check here if you would like the Dr. to decide the best type of care for you.

*By my signature below, I authorize **ChiroCare of Fort Collins, P.C./Rocky Mountain Chiro Care, P.C.** to request or discuss any pertinent records, or to release any information deemed appropriate to any doctor, insurance company or attorney in the course of my treatment or in order to process any claim for reimbursement of charges. I hereby assign all right, title and interest relative to insurance benefits to **ChiroCare of Fort Collins, P.C./Rocky Mountain ChiroCare, P.C.** I clearly understand and agree that I am personally responsible for payment of all services rendered to me. Further, in the event that my account is turned over for collection, I understand that I will be responsible for any interest charges, attorney fees, collection costs and court costs incurred in collecting the balance.*

By my signature below, I acknowledge that there are inherent risks involved with spinal manipulation. In 1995, Rand reported that risk of serious complication approximate 1 in 1 Million to 1 in 1.5 Million. I authorize the doctor to diagnose and treat my condition as deemed appropriate, including the use of spinal manipulation. I understand the above information and guarantee that this form was completed correctly to the best of my knowledge.

Signature: _____

Date: _____

If Minor, Parent or Guardian Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICE SUMMARY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) affords individuals certain rights to privacy regarding protected health information. While we've always protected your privacy concerning your personal health information, this summary discloses how your health information may be used. An expanded notice of your privacy rights is available for review upon request. Be aware that the terms of this notice may change from time to time and that you may contact us at anytime to obtain the most current copy of this notice.

ChiroCare uses your health information for your treatment (including direct or indirect treatment by other healthcare providers), to obtain payment for treatment from third party payors (for example, an insurance company), to evaluate the quality of care that you receive, and for administrative purposes.

ChiroCare may use your health information in the day-to-day operations of our practice. This may include, but not be limited to daily sign in sheets, sending appointment reminders, phone messages, birthday cards, newsletters, holiday greetings and information about treatment alternatives or other health related issues.

ChiroCare may disclose your health information for public health activities, research, health and safety, governmental function in order to comply with worker's compensation laws and other pertinent legislative rules and regulations. ChiroCare will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. You have a right to request restrictions on how your health information may be used and disclosed to carry out treatment, reimbursement, and healthcare operations. ChiroCare may not be required to agree with these requested restrictions, however if we do agree with these requests then we are bound to comply with them. Further, you have a right to request and retain a copy of your health record, request communication of your information by alternative means at alternative locations when appropriate, revoke your authorization and request an accounting of your healthcare records. However, any use or disclosure that occurred prior to the date of revocation is not affected.

You may talk to the Privacy Officer of ChiroCare and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. In the event that a complaint is filed, you will not experience any retaliation.

ChiroCare must maintain the privacy of protected health information as provided by this Privacy Practice Summary. We are obligated to obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under current law.

This office is a semi-private facility. If you wish to discuss clinical or financial information privately, please notify a staff member and we will provide a private setting for that discussion.

In the interest of protecting the privacy of your personal health information, there may be instances when you are asked additional questions to verify your identification. Further, you will not be allowed access into areas designated as "authorized personnel only".

By my signature below, I acknowledge that I have reviewed this information and understand its contents.

Patient Signature

Date

Welcome to ChiroCare!

To give you better service, help our office run smoothly and help you get the most benefit from your care, please observe the following.

- Sign In*** When you arrive for your appointment, please sign in at the front desk. Relax and enjoy some light reading. Think about any changes in your condition or questions that you would like to discuss with the Doctor.
- Check Out*** Prior to leaving, verify your next appointment with the front office staff. Also, take care of any financial arrangements that have been made – payments can be made by cash, check or credit card.
- Keep Your Appointments*** Remember that **consistency** is the key to obtaining the results we both desire. Your treatment plan has been specifically designed to ensure a speedy recovery and provide long term benefit. If you are running late or cannot make your scheduled appointment, please call and we will be happy to reschedule your appointment at a more convenient time.
- Get Involved*** Chiropractic care involves a teamwork approach to better health. One of the goals at *ChiroCare* is to help you understand your condition and what you can do to get better, faster results. Ask questions and follow any treatment recommendations to receive maximum benefit.
- We Welcome Children*** **Especially as patients!** We do have a play area for children, but we ask that parents supervise their children for safety's sake and the consideration of others.
- Refer Others*** Share your chiropractic experience with others. As you improve, please offer hope, direction and encouragement that may benefit others.
- Think Long Term*** In addition to traditional chiropractic care, *ChiroCare* offers *Health Coaching* to improve your overall health and quality of life. Massage therapy, low-tech rehabilitation, nutritional evaluations, lifestyle coaching, laboratory services, orthopedic supplies and custom orthotics are all available through this office.