



Please complete ALL information legibly (if none or not applicable, please indicate so):
*Indicate 'left' or 'right' when applicable and be specific when answering (e.g. names of meds.)

PERSONAL INFORMATION

First Name:
M.I.
Last Name:
Nickname:
Street:
City:
State:
Zip:
Gender: Male Female
Status: Single Married Widowed Divorced
Spouse:
Client DOB: xx / xx / xx
Child(ren): (name/age)

How did you find us?

CONTACT & WORK INFORMATION

Home Phone: ()
Work Phone: () ext:
E-Mail:
Cell: ()
Occupation:
Employer:
Address:
City/State/Zip:
Type of Work: Sitting/Computer Standing Labor
Emergency Contact:
Emer. Phone: ()

PREVIOUS CHIROPRACTIC CARE

Have you ever received chiropractic care? Y N
Doctor Name:
City/State:
Reason:

REASON FOR TODAY'S VISIT

DATE SYMPTOMS BEGAN: / /
Please describe the reason(s) for today's visit:

Since onset, is the condition: Better Same Worse
Rate pain level (1-least 10-most severe):

FOR YOUR FIRST APPOINTMENT:

You must fill out this sheet (double-sided) plus our Chiropractic Client Acceptance Policy & our Privacy Rights Sheet PRIOR to your first appointment in our office - this saves us both time!

ACCIDENT/INJURY INFORMATION

Have you ever had/been in ANY (even minor):
o Auto Accident-Date(s):
o Personal Injury-Date(s):
o Other Trauma-Date(s):
Describe Incident(s):
Treatment Received:

SURGICAL/HOSPITAL INFORMATION

Have you ever had surgery? Y N
If Y, reason:
Result(s)?
Have you ever been hospitalized? Y N
If Y, reason:

MEDICINE/SUPPLEMENTS/OTHER:

Tell us which ones you are taking and why...
o Over-the-Counter Drugs Taken Regularly:
o Prescription Drugs:
o Vitamins/Minerals:
o Herbs/Hormonal Supplements:

PRIMARY CARE PHYSICIAN INFORMATION:

Name of Primary Care Physician:
Practice address:
Phone Number of Practice:
Date of Your Last Physical Examination:
Results of Last Exam: Normal
"x" & Doctor will send treatment notes to this Dr.

FAMILY MEDICAL HISTORY

Table with 4 columns: Disease, Father's side, Mother's Side, Unknown. Rows include Heart Disease, Stroke, Diabetes, Cancer, Arthritis, and Other/Notes on above.

- Please leave excess jewelry (all earrings, necklaces, watches) at home and do not wear perfume or cologne whenever possible.
Bring all paperwork & arrive 15 min.early.



LIFESTYLE & HABITS INFORMATION

Do you exercise: Regularly (3+/wk) Occasionally Rarely Never Weight: _____
Do you smoke: _____ Drink alcohol: _____ Drink Caffeine: _____

CONDITION INFORMATION

Describe Pain Location: _____

Mark all applicable symptoms:

<input type="radio"/> Fever	<input type="radio"/> Headaches	<input type="radio"/> Ears Ring	<input type="radio"/> Cold Sweats	<input type="radio"/> Loss of Taste
<input type="radio"/> Diarrhea	<input type="radio"/> Neck Pain	<input type="radio"/> Irritability	<input type="radio"/> Constipation	<input type="radio"/> Loss of Smell
<input type="radio"/> Tension	<input type="radio"/> Stiff Neck	<input type="radio"/> Cold Hands	<input type="radio"/> Chest Pains	<input type="radio"/> Short of Breath
<input type="radio"/> Fatigue	<input type="radio"/> Back Pain	<input type="radio"/> Cold Feet	<input type="radio"/> Dizziness	<input type="radio"/> Light Sensitivity
<input type="radio"/> Depression	<input type="radio"/> Leg Pain	<input type="radio"/> Nervousness	<input type="radio"/> Sleep Trouble	<input type="radio"/> Buzzing in Ears
<input type="radio"/> Loss of Balance / Fainting / Blackouts		<input type="radio"/> Memory Loss	<input type="radio"/> Stomach Upset	

Sleeping Position:

<input type="radio"/> Stomach	<input type="radio"/> Back	<input type="radio"/> Dull	<input type="radio"/> Sharp	<input type="radio"/> Aching	<input type="radio"/> Burning	<input type="radio"/> Tingling	<input type="radio"/> Swelling	<input type="radio"/> Stiffness
<input type="radio"/> L-Side	<input type="radio"/> R-Side	<input type="radio"/> Shooting	<input type="radio"/> Cramping	<input type="radio"/> Throbbing	<input type="radio"/> Numbness	<input type="radio"/> Other	_____	

Mark all applicable activity limitations:

<input type="radio"/> Lifting	<input type="radio"/> Sitting	<input type="radio"/> Bending	<input type="radio"/> Standing	<input type="radio"/> Running	<input type="radio"/> Walking	<input type="radio"/> Stairs	<input type="radio"/> Other: _____
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Does the condition interfere with: Work Sleep Routine Exercise Other: _____
At certain times of day, is condition: Better - AM / PM Worse - AM / PM Unaffected by time of day
Activities that make condition BETTER: _____
Activities that make condition WORSE: _____

WOMEN ONLY

Is there ANY chance you might be pregnant? N Y Date of Last Menstrual Period: _____
Type(s) of contraceptive currently using: None Condoms Pill Diaphragm IUD

YOUR PERSONAL HEALTH HISTORY

Check all that apply - first section applies to when YOU were born

Y "Your Birth Process"	Y "Current Habits"
1 <input type="radio"/> Long Delivery?	16 <input type="radio"/> Stress At Work?
2 <input type="radio"/> Difficult/Traumatic?	17 <input type="radio"/> Stress At Home?
3 <input type="radio"/> Forceps/Suction Used?	18 <input type="radio"/> Relationship Stress?
4 <input type="radio"/> Caesarean Performed?	
5 <input type="radio"/> Breech/Cephalic?	Your Current Health Goals
6 <input type="radio"/> Home Birth?	<i>(please check all that apply to you)</i>
7 <input type="radio"/> Mother Given Drugs?	<input type="radio"/> Pain relief
8 <input type="radio"/> Labor Induced?	<input type="radio"/> Rehabilitation
Y "Growth"	<input type="radio"/> Overall better health/wellness
9 <input type="radio"/> Did you suffer falls?	<input type="radio"/> Receive diet/nutrition consult
10 <input type="radio"/> Childhood Illnesses?	<input type="radio"/> Begin exercise program
11 <input type="radio"/> Accidents?	<input type="radio"/> Learn about family care
12 <input type="radio"/> Surgery?	<input type="radio"/> Learn more about orthotics
13 <input type="radio"/> Drugs/Antibiotics?	
14 <input type="radio"/> Emotional Trauma?	<input type="radio"/> Other: _____
15 <input type="radio"/> Other Trauma(s)?	_____

DOCTOR CONSULTATION NOTES:

FINANCIAL RESPONSIBILITY INFORMATION

• Payment is expected at the time services are rendered. Payments may be made with exact cash, personal check or Visa/Mastercard. Weekly or monthly advance payments are always welcome.

Print Your Name: _____
Signature: _____ Date: _____

Comments - please explain any Y answers below:

**After completing this sheet, continue on to Client Acceptance Policy Sheet & Privacy Rights Sheet*



Terms of Acceptance

When a person seeks Chiropractic health care and we accept a person for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a Chiropractic spinal examination, we encounter non-Chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Chiropractic care on this basis.

Signature _____ date _____

Consent to Evaluate and Adjust a Minor

I _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature of Parent/Guardian _____ date _____

Chiropractic Durango

Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Chiropractic Durango.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand 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. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

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

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. 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 of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at Chiropractic Durango. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Printed Name of Patient

Date of Signing

Description of Personal Representative's Authority

Chiropractic Durango

Notice of Privacy Practices (3/03)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health

information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

- (1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
- (2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
- (3) You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.
- (4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.
- (5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
- (6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, <http://www.hhs.gov/ocr/hipaa>.

All questions concerning this Notice or requests made pursuant to it should be addressed to
PRIVACY OFFICER, 555 Rivergate Lane, Suite B1-108, Durango, CO 81301