

DENVER CHIROPRACTIC CENTER

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Are you in the right place?

Please read this before proceeding with paperwork:

At Denver Chiropractic Center, we specialize in treating muscles with Active Release Technique®. With that in mind, the first thing that we will do is determine if your problem is indeed muscular in nature. There is about a 98% chance that this is the case. Should you be in the 2% that needs to see someone else, I will tell you today and help you find someone to help you. If that is so, there will be no charge for today's visit. Keep in mind that underlying medical problems may exist, and you should always make your primary care provider aware of any symptoms that you are experiencing.

Usually, there is a sequence of events that brings a patient like you to Denver Chiropractic Center. These steps can unfold over a period of days or a period of years:

- Your muscles are subjected to injury, repetitive motion, and/or chronic tension.
- Your body reacts with tightness, spasms, and inflammation.
- Scar tissue is created, causing your muscles to stiffen and stick together.
- You start to lose range of motion; and feel pain, weakness, and other symptoms.
- Other muscles compensate, and this over-stresses them.
- The body begins to "learn" that all of this dysfunction is "normal".

The symptoms that brought you here are a part likely of a cycle of injury, physical stress, and muscular dysfunction. To restore full, free, and painless motion to your muscles, we will use a proven, specific, step-by-step recovery process:

- Identify which of your muscles are involved.
- Use Active Release Technique® to break up scar tissue within and between your muscles. This allows you to move freely again.
- Address any spinal joint restrictions with gentle adjustments.
- Increase your strength and flexibility. This will prepare your body to handle whatever stresses you subject it to (sports, work, etc...).
- Teach you how to prevent the problem from coming back.

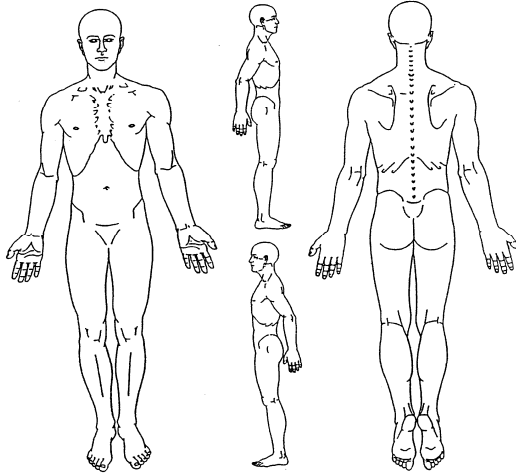
On average, between 4-10 treatment visits may be required to correct your problem. Please feel free to ask as many questions as you want to. My job is not only to fix the problem that brought you here, but also to make sure that you are completely comfortable with and fully understand your treatment. If your condition does not begin to improve after 4 visits, a second opinion from a medical provider is appropriate. Also, should your symptoms return after successful treatment, you should contact your primary care provider. We strongly encourage you to see your medical provider regularly. Soreness may be a side-effect of your treatment. Please report any worsening of your symptoms to us immediately. Chiropractic adjustments carry small risk of injury. If you have any questions about this risk, please feel free to ask.

SIGNATURE

PRINT NAME

DATE

Please mark the areas of your symptoms below.

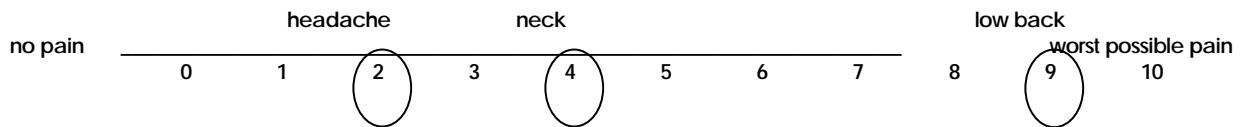


Use letters below to indicate type and location of discomfort		
A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER

INSTRUCTIONS: Please circle the number that best describes the question being asked.

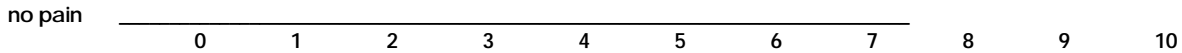
NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate your average pain level since the last time you completed this form.

EXAMPLE:

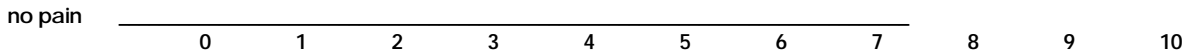


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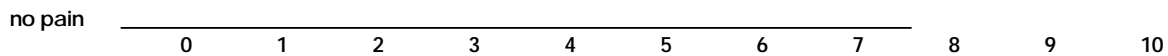
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

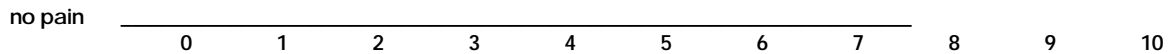


3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____%

LIFESTYLE QUESTIONNAIRE

Please answer all questions frankly, to the best of your knowledge.

Blood Pressure (if known) _____ % Body Fat (if known) _____

1. Any surgeries, hospitalizations, recent illnesses?

2. Any medications or supplements? _____

3. How would you describe your diet: good okay bad

4. Describe your caffeine intake: Coffee: cups/day _____

Other sources? _____

Do you smoke? Y / N

Do you use alcohol? Y / N

5. List what kinds of exercise do you do and how often you do them:

6. Rate your energy level: Very Low Low Average Excellent Highs and Lows

7. At which times during the day do you feel: best? _____ worst? _____

8. What are your main sources of stress? _____

9. How do you deal with your stress? _____

10. Have you been having any problems with :

Eyes. Yes No

Ears. Yes No

Nose. Yes No

Teeth / Mouth / Throat. Yes No

Skin. Yes No

Heart / Cardiovascular system. Yes No

Lungs / Respiratory system. Yes No

Digestive system. Yes No

Reproductive system. Yes No

If yes, please explain:

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Massage Intake, Personal History:

Have you ever had a professional massage before? Yes No How Recently? ____

Please indicate any condition(s) that apply to you:

Do you have diabetes? Y N	Do you suffer from arthritis? Y N
Are you pregnant? Y N	Do you suffer from joint swelling? Y N
Do you have numbness or stabbing pains? Y N	Do you have epilepsy or seizures? Y N
Do you have high blood pressure? Y N	Do you have varicose veins? Y N
Do you have Osteoporosis? Y N	Are you wearing contact lenses? Y N
Are you sensitive to pressure or touch? Y N	Do you have any allergies? (include topical) Y N
Are you wearing dentures? Y N	Do you bruise easily? Y N

Have you had any broken bones, major surgeries, or suffered from any major injuries in that your Massage Therapist should know about?

Please list any medications you are taking:

I understand that the massage therapist does not prescribe medical treatment or pharmaceuticals, or nor does he/she perform any spinal adjustments. Massage therapy is not a substitute for medical examinations and diagnosis. It is recommended that I see a physician for any physical ailment that I might have. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorders. Any sexual misconduct exhibited by the client will result in immediate termination of the session, and the client will be liable for payment of scheduled appointment. If for any reason the client is uncomfortable, the client may ask the therapist to cease the massage and the therapist will end the session.

I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

All the information provided above is, to the best of my knowledge, correct and current.

Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

Yes, we know you have a coupon. The following page applies for future visits, if you'd like to skip this page for now, that's just fine.

PAYMENT POLICY*

We offer 2 options regarding payment in this office.

Please mark an **X** next to the one you choose:

 1. **Check here if you have Aetna, Blue Cross, United Healthcare, Great West, PacifiCare, Kaiser PPO, or Mail Handlers Benefits Program.**

Policy # _____ Group # _____

This office is under contract with these companies, and must bill them. **You are responsible for your co-pays at the time of service and any deductibles on your policy.** We are contractually bound by their fee schedules.

 2. **Pay for services when they are rendered, \$75, and, if you have insurance not listed above, seek reimbursement from your insurance company yourself.**

You will get a receipt for payment if you request one. You may then submit this receipt to your insurance company and seek reimbursement directly from them. Please be aware that we will **not** communicate with your insurance company on your behalf. Nor will we return their phone calls or respond to their letters. **You must deal with them directly.** We will, however, communicate with you if needed. (Discounted packages of 10 visits are available for \$650, saving you \$10 per visit)

Cancellation policy:

If you must cancel an appointment, please do so at least 24 hours before the scheduled time. Without 24 hour notice, there will be a \$75 fee. Weather-related exceptions will be considered, as well as legitimate emergencies.

I understand this disclosure. I agree that a copy of this document shall serve as original. I understand that my health insurance is a contract between myself and my health insurer, and ultimately I am responsible for my account at Denver Chiropractic Center.

Signed: _____

Date _____

Print Name: _____

*This policy is based on recommendations by the CO State Board.