

DENVER CHIROPRACTIC CENTER

GLENN D. HYMAN, DC, CSCS

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.
- Retrain your body in normal movement patterns to "unlearn" dysfunctional patterns. This helps your body "remember" that full and free motion is normal again.
- 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 4-8 treatment visits may be required to fully 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.

SIGNATURE

PRINT NAME

DATE

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BACKGROUND INFORMATION:

Name: _____ Date: _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____
Birth date: _____ Gender: _____ Marital Status: _____ Height: _____ Weight: _____
M F M S No. Children: _____

Sign up to receive the weekly version of the newsletter—“Dr. Glenn’s Stronger-Leaner-Better Letter”—featuring information on training, nutrition, recovery, and other good stuff, available only by email. The list is never shared with anyone.

Email: _____

Occupation: _____ Years There: _____

Employer & Address: _____

Describe your major complaint: _____

When did this start? _____ Is it: getting better getting worse the same

How did it start? _____

Other complaints? _____

What are your overall health goals once your complaints are resolved?

Other than the health concerns already noted, check any of the following with which you would like support:

- _____ Sleep better
- _____ Have more energy / experience less fatigue
- _____ Learn to reduce stress
- _____ Be more flexible
- _____ Start an exercise program
- _____ Get fewer colds
- _____ Reduce body fat

LIFESTYLE QUESTIONNAIRE

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

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

1. List any medications, nutritional supplements or vitamins you are currently taking:

2. How much sleep do you average? _____

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

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

Tea: cups/day _____

Soda: cans/day _____

Water: glasses/day _____ Bottled Filtered

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

6. Are you happy with your weight? _____

If not: What do you feel triggered your weight problems? stress eating habits boredom

Was your weight gain/loss: sudden gradual problem since childhood

What methods have you tried to lose/gain weight?

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

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

9. What are your main sources of stress? _____

10. How do you deal with your stress? _____

11. Please answer the following questions:

I've recently had a series of annoying injuries. Yes No

I sometimes have a hard time going to sleep or staying asleep. Yes No

I get tired and/or hungry in the mid-afternoon. Yes No

I need caffeine to get through the day or get the day started. Yes No

I think I am a "stress eater." Yes No

I have occasional or frequent digestive problems (gas, bloating, pain, etc). Yes No

I have symptoms of anxiety and/or depression. Yes No

I experience cravings for sugar, breads, pasta and baked goods. Yes No

I often find myself irritable or angry. Yes No

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 United Healthcare or Great West.**

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, 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.

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 \$70 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.

Signed: _____

Date _____

Print Name: _____

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