DENVER CHIROPRACTIC CENTER

BACKGROUND INFORMATION:

Name: ______________________ Date: ____________

Address: ______________________ Home Phone: ____________

City: ____________ State: ____ Zip: ________ Cell Phone: ____________

Birth date: __________ Gender: M F Marital Status: M S Height: ________ Weight: ________

No. Children: _____

Please choose if you would like to receive email or text reminders for your appointments:

EMAIL: ___ TEXT:___ BOTH:___ NEITHER:___

For text message please list your Mobile Carrier: ______________________(message & data rates may apply)

Please provide us with your email address so that we can communicate with you about your appointments and treatment program, including emailing your rehab exercises to you.

Email: ______________________

Occupation: ______________________ Years There: _______

Employer: ______________________

How did you hear about us? ______________________

Describe your major complaint: ______________________

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

How did it start? ______________________

Other complaints? ______________________

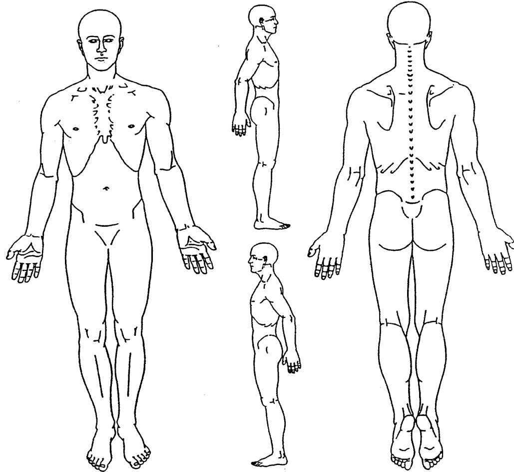
____

We offer two types of treatment programs in our office, please choose the one that is more appropriate for you:

______ACUTE SYMPTOM CARE: I am only concerned about relief of symptoms at this time.

______CORRECTIVE /PREVENTATIVE CARE: I am concerned about symptom relief AND finding the underlying causes in order to prevent the return of symptoms in the future.

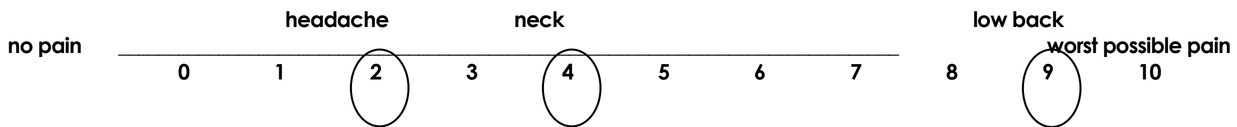
Please mark the areas of your symptoms below.



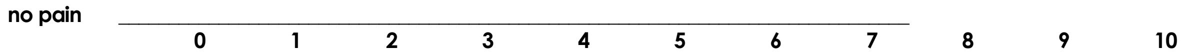
Use letters below to indicate type and location of discomfort		
A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER

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.

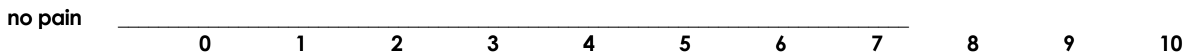
EXAMPLE:



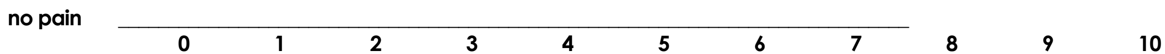
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

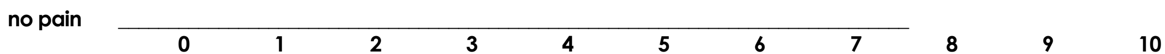


3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



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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Voice 303.300.0424 Fax 303.648.5456 www.denverback.com

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 Anthem Blue Cross / Blue Shield, United Healthcare, Aetna, Cigna, Humana or an auto insurance case (If your plan is not listed here, please ask).**

Policy # ______________ Group # ____________________

Insurance Company: ____________________________

This office is under contract with these companies, and must bill them. The fee schedule is determined by each carrier, not by us. **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, but you are still ultimately responsible for your account.

____ 2. **Pay for services when they are rendered, $60, 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. Pre-paid packages of 10 visits are available for $550 ($55 per visit). This must be paid in full in advance to qualify for the discount.

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 $60 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.

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Denver Chiropractic Center.   Glenn D. Hyman DC

Denver Chiropractic Center
Informed Consent

Patient Name:	**Date:**

Chiropractic healthcare is an art and a science that is primarily concerned with the relationship between structure (primarily of the spine) and function (primarily of the nervous system). The doctor of chiropractic evaluates the patient using standard examination and testing procedures (such as orthopedic and neurological evaluation, labs, x-rays) along with specialized chiropractic evaluation. The chiropractic evaluation focuses on structural and/or functional abnormalities called “Intersegmental Dysfunction (ISD)”. ISD exists when one or more vertebrae in the spine or bones in the extremity are misaligned sufficiently enough to result in damage or irritation to either the nearby nerves, joints, and/or tissues. The primary goal of chiropractic treatment is the removal of ISD. This is accomplished by performing a procedure unique to the chiropractic profession called an “adjustment”. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physiotherapy modalities (e.g. heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations, and rehabilitative procedures.

As is the case with all health care interventions, the benefits of care must be weighed against the inherent risks and limitations of receiving treatment. Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Nonetheless, they must be considered when making the decision on whether or not to receive chiropractic care. Listed below are summaries of some key research articles that have addressed both common and rare side-effects/complications associated with chiropractic care.

One research study indicated that within the first 2 months of care, approximately half of patients report some “reaction” to chiropractic treatment. Of those who reported a reaction, the following were the most commonly reported reactions to initial chiropractic care [1]:

- Local discomfort (53%)
- Headache (12%)
- Tiredness (11%)
- Radiating discomfort (10%)

Most appeared within 4 hours of treatment and resolved within 24 hours.

Denver Chiropractic Center.   Glenn D. Hyman DC

Rare, Yet Possible Side-Effect/Complications

- Rib fracture
- Disc herniation
- Cauda Equina Syndrome [2] (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (i.e. stroke) (1 case per 400,000 to 1 million cervical spine adjustments) [3]

In addition to national guidelines [4], our clinic has set criteria for how we manage our patients. Through questioning and examination, we will do our best to determine what risk, if any, chiropractic care may pose to you and advise you of those risks as well as the possible need for medical referral. We may also suggest alternate chiropractic or medical approaches if we detect absolute or relative contraindications to the standard chiropractic treatment.

1. **Senstad O, et al. . Frequency and characteristics of side effects of spinal manipulative therapy. Spine 1997;22:435-41**
2. **Shekelle PG, et al. Spinal manipulation for low-back pain. Ann Intern Med 1992;117(7):590-8.**
3. **Haldeman S, et al. Risk factors and precipitating neck movements causing vertebrobasilar artery dissection after cervical trauma and spinal manipulation. Spine 1999;(24):785-94.**
4. **Haldeman S, et al. Guidelines for chiropractic quality assurance and practice parameters. Aspen Publishers, 1997.**

I have read and understood the previous information regarding risks of chiropractic care.
I also certify that all the information I have provided the doctor and staff upon my intake is true and complete to the best of my knowledge.

PATIENT'S SIGNATURE ________________________________ DATE ________________

PARENT/GUARDIAN'S SIGNATURE

________________________ DATE ________________
(if appropriate)

DOCTOR'S
SIGNATURE ________________________________ DATE________________

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ____
(PRINT NAME PLEASE)

Signature: ____ Date: ________________

Witness: ____ Date: ________________