ALPINE CHIROPRACTIC
11990 Colorado Blvd
Thornton, CO 80233

(PLEASE PRINT) DATE:_____

Name_____ Address_____

Cell Carrier/Provider for text reminders: _____

City, State, Zip_____ Home #_____ Cell #_____

Social Security #_____ Birthdate_____ Age_____ Height_____ Weight_____

No. of Children_____ Marital Status: M S D W Name of Spouse or Parent_____

Your Occupation_____ Employer_____ Work #_____

Employer Address_____ City, State, Zip_____

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

Have you ever had Chiropractic Care before?_____ If so, when?_____

List your chief complaints in order of severity:

(1)_____ For how long?_____

(2)_____ For how long?_____

(3)_____ For how long?_____

List other doctors consulted for these conditions:

(1)_____ Address_____

(2)_____ Address_____

Is this injury or illness work related?_____ If yes, have you reported it to your employer?_____

Is this injury or illness related to an automobile accident?_____ If yes, name of your Auto Ins. Co:_____

Policy #:_____ Claim #:_____ Agent Name:_____

Agent Address:_____ Agent Phone #:_____

List any previous auto accidents:_____

_____

NOTICE: Not all patients require X-rays to determine or verify diagnosis, type of treatment, or length of treatment. If your examination warrants X-ray analysis, the following office policy prevails:

(1) All first-visit charges, with or without X-rays, are payable when service is rendered.

(2) The fee paid for treatment X-rays is for analysis only. The film itself is the property of this office and remains part of your permanent records.

Method of payment you plan to use to take care of today's charges:
☐ Check ☐ Cash ☐ MasterCard ☐ Visa

List any medications you are currently taking:

_____ _____ _____

_____ _____ _____

Surgery (Please include all surgery)

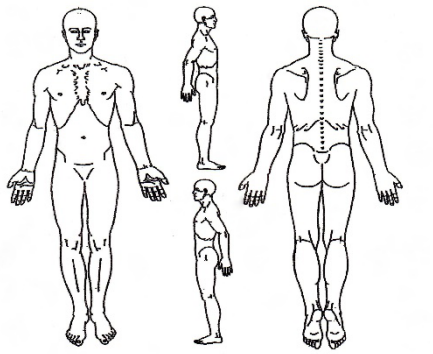
(1) Type_____ When_____

(2) Type_____ When_____

(3) Type_____ When_____

ARE YOU NOW OR HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING:

- ☐ Stroke
- ☐ Fatigue
- ☐ Migraine
- ☐ Nervousness
- ☐ Arthritis
- ☐ Numbness or pain in arms/legs/hands
- ☐ Pregnant at this time
- ☐ Pain between shoulders
- ☐ Spinal curvature
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Headache
- ☐ Shingles
- ☐ Dizziness
- ☐ Heart Attack
- ☐ Cancer
- ☐ Diabetes
- ☐ Sinus
- ☐ Stiff neck
- ☐ Backache
- ☐ Swollen joints



Please mark your areas of pain on the figures above

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain: 0 Absent to 10 Extreme

Are your symptoms:

☐ Getting worse ☐ Getting better ☐ Staying the same

X-RAY CONFIRMATION: This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant and I consent to spinographic pictures.

Signature:_____ Date:_____

CONSENT TO TREAT A MINOR CHILD: I hereby authorize this office to administer chiropractic as deemed necessary for my child.

Signature:_____ Date:_____

NOTES:

Functional Rating Index

For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **ID#/SS#** _____ **Plan ID** _____ **Total Score** _____

PRINTED

_____

Signature

_____

Date

Privacy Acknowledgement

The Privacy Policies and Procedures are effective as of April 14, 2003. This notice will expire seven years after the date upon which the record was received. By signing below, I acknowledge that I have read these Privacy Policies and Procedures and may request a copy of them at any time.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Authorized Provider Representative

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy notices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify) _____

Office Personnel (signature) _____ Date: _____

Assignment of Benefits

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered by this clinic.

_____ _____

Patient Signature Date

Release of Information

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and hereby release this clinic of any consequence thereof.

_____ _____

Patient Signature Date

Financial Responsibility

I agree to be financially responsible for any and all charges incurred at this clinic, including but not limited to my insurance deductible, copayment, any services rejected by my insurance company, as well as any collection costs. ***In addition, all missed appointments will be charged a $25.00 fee.***

_____ _____

Patient Signature Date

ALPINE CHIROPRACTIC 11990 Colorado Blvd Thornton, CO 80233 303-920-9486

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social wellbeing, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If, during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of the findings and recommend that you seek the services of another healthcare provider.

Chiropractic care, including spinal adjustments, has been the subject of government reports and multidisciplinary studies, conducted over many years and has been demonstrated to be highly effective. Chiropractic care is considered to be one of the safest and most effective forms of health care. I am informed and I understand that doctors of chiropractic, medical doctors, and physiotherapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there may be some minimal risk associated with care, including but not limited to: muscle strain, ligament sprain, rib fracture, disc injury, and stroke. There have been reported cases of injury to a vertebral artery following cervical spinal adjustments. The risk of injuries or complications from chiropractic care is substantially lower than those associated with many medical treatments, medications, and procedures given for the same concerns. To put this in perspective, the risk of stroke in the general population is 0.00057%. The risk of stroke after a chiropractic adjustment is 0.00025%. The risk of death from taking an aspirin and/or other anti-inflammatory drugs is 0.04%. (Information released from: The National Center for Health Statistics USA 1993 and A Risk Assessment for Cervical Manipulation vs. Non-Steroidal Anti-inflammatory Drugs for the Treatment of Neck Pain, JMPT Oct 1995) I do not expect the doctor to be able to anticipate or explain all risks and complications. I expect the doctor to exercise and employ clinical judgement as well as physical examination and screening procedures during the course of my care.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statement and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

Consent to evaluate and adjust a minor child:

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

Pregnancy Release:

This is to certify that, to the best of my knowledge, I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____ _____ _____

Signature Date