All Seasons Chiropractic
Sustainable Health Center
8751 E. Hampden Ave. #C3
Denver, Co. 80231
Tel: 303-750-5220

Welcome

Welcome

We are glad you are here!!

Please completely fill out all applicable information

Patient Name · _____ ____ _____
First Middle Init. Last

Address · _____ _____
Street Apt

_____
City State Zip

Best Phone Number to Reach You: _____

Email _____

Gender · M F Birth Date _____

Occupation/ Employer · _____

Marital Status · M / S / D / W / SEP

Spouses' Name · _____

Parent/ Guardian Name · _____ (if under 18)

How did you hear about us?

❑ Friend or Family _____
❑Internet
❑Booth ❑Ad ❑Other _____

NOTE: Although All Seasons Chiropractic Clinic will give you all information you need to be reimbursed by your insurance if you have chiropractic benefits, the ultimate financial responsibility remains with you, the patient. By signing this you are consenting to receive chiropractic care.

Patient Signature: _____ Date _____
Patient or Parent/ Guardian Signature (if < 18yr old)

Main Concern · _____
Other Concerns ·_____
_____

(Fill out for your Main Concern)

· Have you had this before? N Y
_____ (when)

· How did this happen? _____

· When did this happen? _____

· What makes the pain *worse*? _____

· What makes the pain *better*? _____

· Please circle the character of your pain:
· Dull / Sharp · Deep / Superficial
· Achy / Stabbing · Numbness (pins & needles) / Burning

· Does the Pain travel down your arm / leg?
N Y, _____ (where)

· Please circle the pain's intensity ·
Slight Mild Moderate Severe

· How often does the pain occur?
· Intermediate (<1/4 of the time) · Frequent (1/2 – ¾)
· Occasionally (1/4 – ½) · Constant (3/4 – 100%)

· Have you lost sleep due to the pain: N Y

· Have you had any unexplained weight loss recently: N Y

· Does it interfere with your work and/or daily living? N Y

What activities would you like to get back to that you are currently unable to enjoy? _____

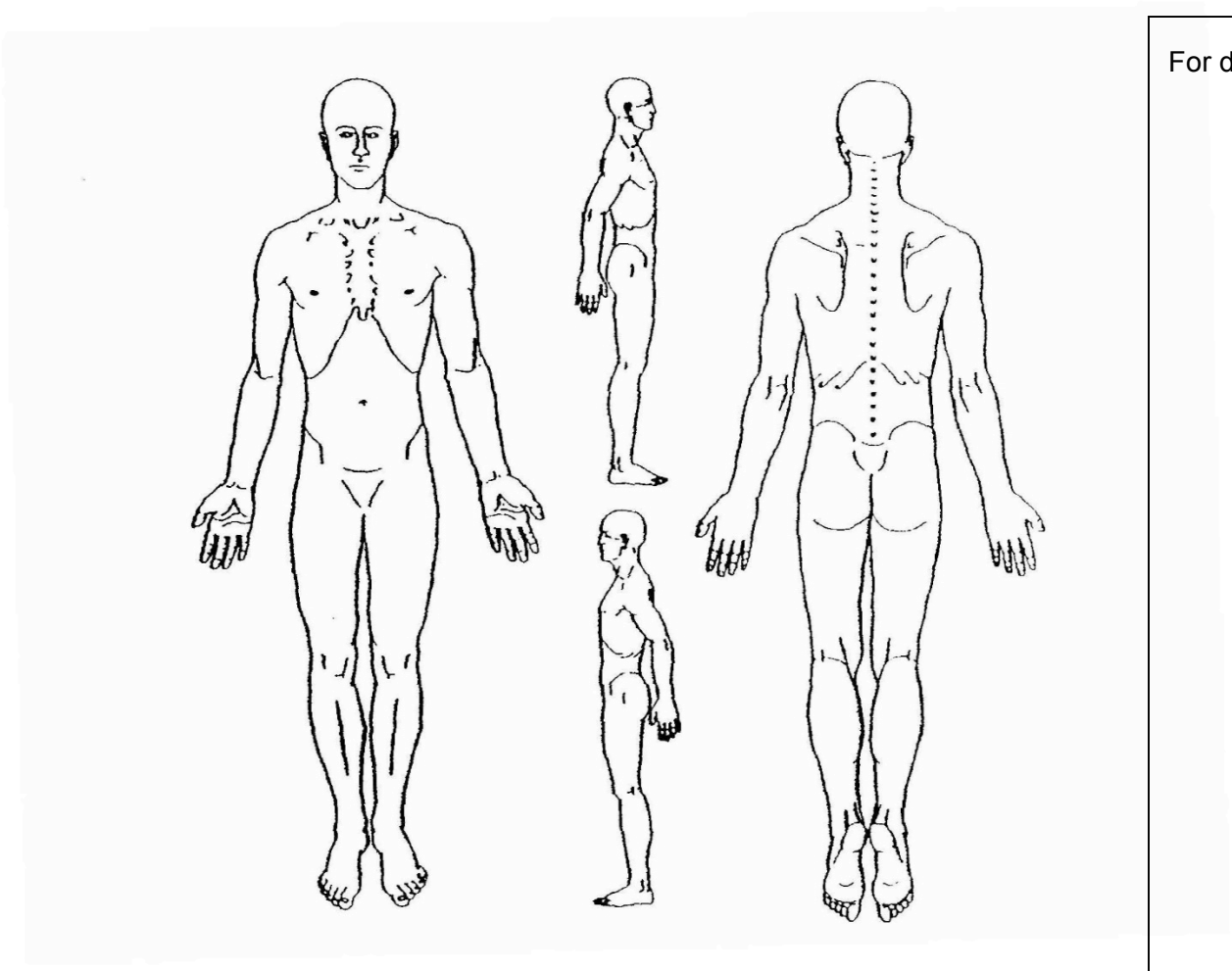
_____

_____

For doctors use only

On the diagram below, using the key, please indicate the location and type of pain/symptoms you are currently experiencing.

P = Pulsing/throbbing pain **T** = Tingles **N** = Numbness, **B** = Burning
A = Achy **X** = Sharp or Stabbing **O** = Other types of sensations



For doctors use only

Please rate your current pain level for today *and* where it is most days on the Pain/Discomfort Scale below:

Slight	**Minimal**	**Moderate**	**Severe**
1----------5----------10			

Patient Signature: _____ Date: _____

·**Have you seen any other doctors for this condition?**
N Y, _____ (who, results)

· **Have you been to a chiropractor before?**
N Y, _____ (who, results)

· **Please List any medications and/or vitamins you currently take:** _____

_____

_____

· **How many servings of fruits and vegetables do you eat per day? 0-2/day 3-6/day 7-10/day**

For doctors use only

Would you like nutritional recommendations? Y N

·Please circle any conditions that you have had or currently have:

Musculoskeletal	**Nervous System**	**Genito-Urinal**
Low Back Pain Joint Pain/Stiffness Leg Pain Neck Pain Mid Back Pain Muscle weakness Trouble Swallowing Fracture/Dislocation	Arm Pain Numbness Headaches Dizziness Fainting Loss of Balance Seizures Stroke Depressions Paralysis	Excessive Urination Difficult Starting/Stopping Change in color Prostate: Last Exam: ___ Discharge Urinary Tract Infections Flank/ Pelvic Pain Birth Control Pills _____ Change in Sex Drive Pain During Sex
Eye/Ear/Nose/ Throat Pain in Eyes Visual Problems Difficulty Hearing/Deaf Ringing in Ears Allergies Nose Bleeds TMJ/ Pain in Jaw	**Cardiovascular** Heart Disease Edema/Swelling Pneumonia/ Lung Infection Fatigue Wish to Lose Weight	**Gastrointestinal** Disinterest in food Diarrhea Constipation Tummy Aches

·**Do you or any of your family members have a history of Cancer, Heart Disease, Diabetes, Neurological Disorders (Parents, Grandparents)?**

_____

_____

Any work injuries at any job in the past? N, Y _____

Are you currently under treatment for any work related injury or other accidents? N, Y

Is there any chance that you could be pregnant at this time? N, Y

Do you have any additional concerns that have not been covered in this intake form? _____

Doctors Notes:

MVA_____

_____

_____

Surgeries _____

_____

_____

Fx Dis _____

_____

_____

Illnesses _____

_____

_____

Other _____

_____

_____

_____

_____

_____

_____ _____

Dr Signature **Date**

Discounted Exam Information

I understand that due to a promotion put forth by this office I am receiving my initial physical exam (normally $150) at a discounted rate (just $39 for you!!). This exam includes, but is not limited to nerve and muscle tests, motion evaluation for joints, vital signs, orthopedic exams, and general movement/symptom evaluation. This exam will be as complete and detailed as all exams given by our doctors regardless of discounted rate. Care given following your initial exam and visits following initial exam are *not* included. Additional charges **rarely** needed for x-ray referrals or referrals for further testing are not included and will be discussed **before** they are incurred. If you have any questions regarding charges please ask us.

Patient name: _____

Patient Signature: _____ Date: _____

No Show/Cancellation Policy

We require 24 hours notice if you need to cancel or reschedule your appointment. Last minute changes may incur a **$65 charge** for the missed appointment or late cancelation. If you need to *re-schedule* the appointment due to unforeseen circumstances the charge *may* be waived as long as you call two hours prior to the start of your appointment time and reschedule that appointment. Since we choose to be very through and work on your whole body each visit we require a certain amount of time to get you all better. So, if you are more than 8 minutes late to your appointment, that will be considered a missed appointment you will have to re-schedule and you *may* incur the $65.00 charge.

This is to keep my and your schedules running smoothly.

Thanks for your understanding.

All Seasons Chiropractic Sustainable Health Center

Signing this states you have read and agree to comply with the no show policy at All Seasons Chiropractic Clinic. If you wish to have a copy of this notice just ask.

Sign _____ Date _____

Informed Consent Form

Every type of health care is associated with some risk of potential problems. State law requires that you sign an informed consent form prior to receiving care.

I, _____, hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and soft tissue work, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

Soreness is the most common reported after effect following an adjustment. Usually this is because an adjustment restores normal motion to joints which may tear scar tissue and produce muscle soreness.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as with any medical treatment, chiropractic adjustments may have some risks associated with treatment, including but not limited to headaches, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I also understand the risks of **Non-treatment**: I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. Putting treatment off may complicate future treatment making recovery and rehabilitation more difficult and lengthy.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to chiropractic and related treatments prescribed by chiropractors at All Seasons Chiropractic Clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date _____

Witness Signature _____ Date _____

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that on request I will receive a copy of the current HIPAA form containing Notice of Privacy Practices.

_____ _____

Signature of patient or personal representative Date

_____

If signed by personal representative, relationship to patient

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Office Use Only:

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient name: _____

Refused to sign ☐ Physically unable to sign ☐

(Other)_____

_____

_____

_____

Employee Signature:_____ Date:_____