New Patient Intake Form

Patient Information

Name_____Date of Birth _____Date_____

Address_____City/State_____Zip_____

Phone _____Email Address (for clinic news)_____

Gender_____Marital Status_____#Children_____

Occupation_____Company Name_____Work Phone_____

Spouse/Gaurdian's Name_____Occupation_____

Contact Name, In Case of Emergency_____Phone_____

How Did You Hear About Our Clinic?_____

Have You Been To A Chiropractor Before?_____Last Visit?_____Location?_____

Primary Insurance (please skip if you are not using insurance)

Name of Primary Account Holder_____Relationship to Patient_____

Birth Date_____Social Security #_____Phone#_____

Address (if different from patient)_____City/State_____Zip_____

Insurance Company_____Additional Insurance?_____

Deductible_____CoPay_____Coinsurance_____

Assignment of Benefits | Release of Records

I authorize my private insurance companies to make payment to Denver Chiropractic, LLC for all services provided by Denver Chiropractic, LLC. I give permission for my doctors and any holder of my medical records to be released by Denver Chiropractic, LLC. I will provide all information needed to process my claims in a timely manner. I understand that I am responsible for all products/services provided to me, including the balance remaining after payment of insurance payments. If my private insurance does not pay I will be responsible for full payment of balance (including co-insurance, deductibles, and non-covered services).

Signature_____

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Current Health Concerns

List Conditions in Order of Importance	When Did it Start?	Pain,0-10, 10 is worst	% of day it bothers you
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

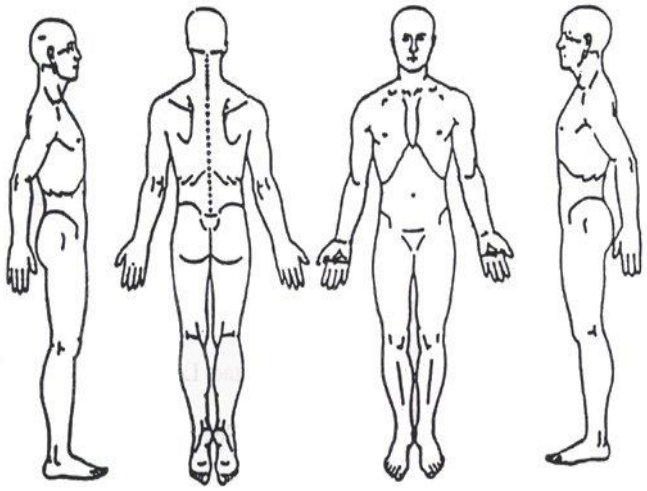
Condition #	What Makes it Worse?	What Makes it Better?	Description of Symptoms (achy,numb,etc.)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Condition #	x-ray/MRI	Prior Episode Y/N	Pain Start from an Injury, or Gradual?	Getting Better/Worse?
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Shade the Painful/Symptom Areas

List Other Professionals You Have Seen For This Problem

_____



1. **Family Health History** (circle any that apply) auto-immune, spine problems, arthritis, cancer, diabetes, heart disease, kidney disease, metal disorder, bleeding disorder, seizures.

2. Your Personal Physician (name, phone)_____

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Past/Current Health Condition

General Current Conditions

__Recent Accident
__Muscle Spasms
__Restricted Movement
__Numbness/Tingling
__Radiating Pain
__Headaches/Migraines
__Sinus Problems
__Nausea
__Depression
__Anxiety
__Dizziness/Vertigo
__Hearing Problem
__Sleeping Trouble
__Asthma/Breathing Problem
__Digestive Trouble
__Heartburn/Acid Reflux
__Menstrual Problems
__Jaw/Mouth Problem
__Arm/Shoulder/Elbow/Hand Prob.
__Leg/Hip/Knee/Foot Prob.

Diagnosed Conditions

__Born with Bone/Joint Disorder
__Degenerative Arthritis
__Rheumatoid Arthritis
__Compression Fracture
__Heart Attack/Heart Disorder
__History Stroke/Aneurysm
__Cancer
__Diabetes
__Gout
__Autoimmune Disease
__Ankylosing Spondylitis
__Immune Suppression Treatment or Disorder from Chemotherapy, Organ Transplant
__Tuberculosis
__Hepatitis B or HIV Infection
__Multiple Sclerosis
__Thyroid/Hormone Disorder
__High Blood Pressure
__Convulsions/Epilepsy
OTHER:

Specific Pain In The Body

__Difficulty Swallowing due to Neck Pain
__Pain/Electric Shocks in Arms/Legs When Moving Neck
__Leg Pain Worse with Exercise
__Numbness of Inner Thighs
__Back Pain with Urinary Problems
__Severe Pain that Interrupts Sleep
__Constant Pain that doesn't Improve by Changing Positions or Lying Down

Specific Current Conditions

__Poor Balance
__Loss of Bowel/Bladder Control
__Blurred/Double
__Vision/Dizziness/Faintness When
__Neck is in Certain Positions
__Memory Loss After Injury
__Recent Unexplained Weight Loss
__Recent Progressive Muscle Weakness/Shaking

OTHER:_____

Health Information

1. List Any Surgeries/Hospitalizations_____

2. List Presciptions_____

3. List Over-the-Counter Medications_____

4. List Supplements_____

5. Are You Pregnant?_____ 6. Date of Last Period_____7. Height/Weight_____

8. Recent Fevers/Serious Illnesses_____ 9. Any Tobacco Use? How Much & How Long_____

10. Do You Exercise?_____What Type?_____How Often?_____

11. Any Allergies?_____ 12. How Do You De-Stress?_____

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Consent to Examination & Treatment

I hereby request and consent to the performance of chiropractic examinations, adjustments, dry needling, graston technique, active release technique, flexion-distraction therapy, moist heat, electrotherapy, ultrasound, kinesio taping, and other procedures on me (or the patient named below, for whom I am legally responsible) by the licensed doctors at Denver Chiropractic, LLC. I understand and I am informed that, in the practice of chiropractic that there are some risks to examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains, pneumothorax, increased symptoms, or no improvement. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future conditions for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices

Our Privacy Policy

The office of Denver Chiropractic, LLC is committed to upholding the security and confidentiality of personal information that you provide to us. We take our responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship. I hereby authorize that my records of evaluation and treatment with the office of Denver Chiropractic, LLC may be forwarded to referring physicians, specialists, or therapists who are also involved in my healthcare.

Office Policies

1. An average case of acute neck or back pain typically takes between 6-12 office visits for it to resolve. Chronic pain may take more visits. Neck or back pain usually fluctuates, meaning that you might have flare ups along the course of your healing.
2. If you make an appointment and do not show up or call, **we will charge you $30**. Please call if you are unable to make an appointment.
3. If you have never been adjusted you may be sore after your treatment. This soreness is similar to a long hike or a good workout type of soreness. Soreness can be a good response, as is the soreness you get after a good workout.

I understand and have read the consent to treatment and examination, our privacy policy, and our office policies.

Signature _____Date_____

Regarding Our Time of Service Discount – Non Insurance Patients

This is considered a separate agreement between Denver Chiropractic, LLC and you, and does not interfere with your insurance or our health insurance contracts. Our Master Fee schedule is reduced as we save time and money by not utilizing a billing service, not waiting for payment from insurance or your portion of the insurance payment. This is a contractual agreement between Denver Chiropractic, LLC and you, the patient, that we both agree to a reduced price.

Signature_____Date_____

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