Boulder Sport & Spine

Confidential Patient Information Form

Today's Date _____

Name _____ Date of Birth _____ Age _____

Address _____City _____ Zip _____

Phone ( ) _____ Email Address _____

Marital Status: M S W D Children Y/ N # _____

Occupation_____Employer_____

Address_____Work Phone_____

Name of spouse _____ Occupation_____

Employer _____ Work Phone_____

Emergency contact _____ Contact Phone_____

Relationship of emergency contact (Parent/ Other Relative/Friend)_____

Referred By (circle): Yellow Pages / Provider Manual / Other physician / Friend or relative

Name_____

Date of last physical examination Reason for your visit today? _____

Is your visit the result of an auto or work injury? Y/N If yes, which _____

Have you seen other doctors or chiropractors for this problem? Y/N If yes, who_____

Are you currently taking any medications (Prescribed or "Over the Counter")?

_____

Additional information _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Elevated Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. With my signature I hereby state that all of the above information was truthful and accurate to the best of my knowledge.

Patient's Signature:_____Date _____

Guardian's Signature Authorizing Care: _____

Symptom Questionnaire

Name: _____ **Date:** _____

1) **Date Problem Began:** _____
2) **How did your current problem(s) begin:**

_____

_____

_____

3) **Can you perform your daily activities?** ☐**Yes** ☐**NO (Describe)** _____

_____

_____

4) **Have you had spine x-rays, MRI or CT Scan?** ☐**Yes** ☐**NO**

Date(s) taken: _____ **What areas were taken?** _____

Please complete the following questions for each problem that you are having

Problem #1 _____

Problem 1 (How you feel today): **Please Mark an " | " at your current level of symptoms**

No pain or discomfort |———————————————————| Severe pain or discomfort

Since this problem began, are the symptoms: ☐Increasing, ☐Decreasing, ☐Unchanged

How often are your symptoms present?

☐Constant (76-100%) ☐Frequent (51-75%) ☐Occasional (26-50%) ☐Intermittent (25% or less)

Problem #2 _____

Problem 2 (How you feel today): **Please Mark an " | " at your current level of symptoms**

No pain or discomfort |———————————————————| Severe pain or discomfort

Since this problem began, are the symptoms: ☐Increasing, ☐Decreasing, ☐Unchanged

How often are your symptoms present?

☐Constant (76-100%) ☐Frequent (51-75%) ☐Occasional (26-50%) ☐Intermittent (25% or less)

Problem #3 _____

Problem 3 (How you feel today): **Please Mark an " | " at your current level of symptoms**

No pain or discomfort |———————————————————| Severe pain or discomfort

Since this problem began, are the symptoms: ☐Increasing, ☐Decreasing, ☐Unchanged

How often are your symptoms present?

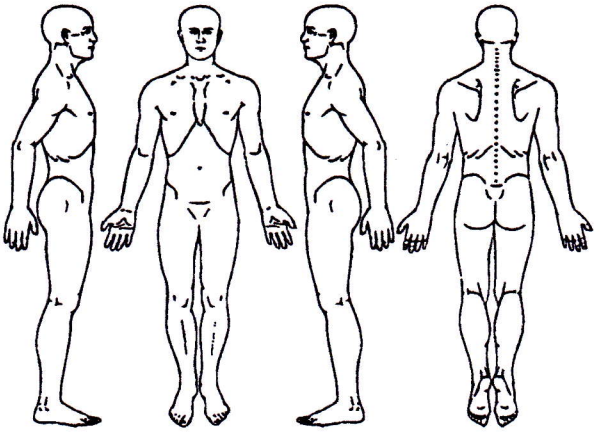
☐Constant (76-100%) ☐Frequent (51-75%) ☐Occasional (26-50%) ☐Intermittent (25% or less)

☐

Doctors' Initials

Name: _____

On the diagrams, mark where you currently have pain or other symptoms. Include symptoms of pain, numbness,tingling, etc..



Please check all of the following that apply to you: ☐ **None Apply**

Yes	No	Condition
☐	☐	History of Recent Infection
☐	☐	Recent Fever
☐	☐	HIV/AIDS
☐	☐	Diabetes
☐	☐	Corticosteroid Use (Steroid inhailer)
☐	☐	Birth Control Pills
☐	☐	High Blood Pressure
☐	☐	Stroke (date) _____
☐	☐	Dizziness/Fainting
☐	☐	Numbness in Groin/Buttocks
☐	☐	Urinary Retension
☐	☐	Aortic Aneurysm
☐	☐	Cancer/Tumor
☐	☐	Osteoporosis
☐	☐	Recent Trauma

Yes	No	Condition
☐	☐	Prostate Problems
☐	☐	Frequent Urination
☐	☐	Pregnancy, # of births _____
☐	☐	Abnormal Weight ☐Gain ☐Loss
☐	☐	Epilepsy/Seizures
☐	☐	Visual Disturbances
☐	☐	History of Low/Mid Back Pain
☐	☐	History of Neck Pain
☐	☐	Arthritis
☐	☐	History of Alcohol Use: # _____ day/wk
☐	☐	History of Tobacco Use: #_____ day/wk
☐	☐	Surgeries/Medications: _____
		_____
		_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems / Stroke

Current Work Activities: Sit more than stand—Stand more than sit—Sit/stand equally—Walking

Previous Auto Injuries: None—Yes, describe _____

Previous Work Injuries: None—Yes, describe _____

Allergies: _____

Exercise Habits: None—Regular Program—Semi-regular program (Describe) _____

_____

I certify that the above information is complete and accurate. I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Signature:_____ Date: _____

Doctors' Notes _____

_____

_____

_____ Initials _____

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Informed Consent to Consent to Chiropractic Treatment of Care

Print patient's name: _____

I, hereby, request and consent to the performance of procedures which are within the scope practice of chiropractic including, but not limited to, chiropractic adjustments, various modes of physical therapy and diagnostic X-rays, on me (or on the patient named above, for whom I am legally responsible) by the doctor of chiropractic named above and/or any other licensed doctor of chiropractic who now or in the future will treat me while employed by, working or associated with or serving as back-up for the doctor or chiropractic named above or any other offices or clinics, including those working at the clinic or office listed above or any other offices or clinics, whether signatories to this form our not.

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

I understand and am informed that there are some risks to chiropractic treatment, including, but not limited to, fractures, disk 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 on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Print name of patient/representative _____ Date _____

Signature of patient/representative _____

Relationship of authority/representative_____