# FOOTHILLS CHIROPRACTIC HEALTH CENTER
# PATIENT INTAKE

Patient Information contained within this form is considered strictly confidential. Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.

Name:________________________ Date of Birth:______________ Today's Date:______________
Street Address:____________________ City:__________________ State:_____ Zip Code:_________
Phone: Home:______________________ WorK:________________ Cell:____________________
E-mail address:_____________________ Employer:______________ Occupation:______________
How did you hear about us at Foothills Chiropractic?_________________________________.
_______________________________________________________________________________.

**General History**

***Mark (c) for current problems, check the box and indicate the age when you had any of the following:***

□ Allergies
□ Dizziness
□ Fainting
□ Fatigue
□ Fever
□ Headaches
□ Loss of sleep
□ Tremors
□ Weight loss/gain
□ Arthritis/rheumatism
□ Bursitis
□ Foot trouble
□ Muscle weakness
□ Low back pain
□ Neck Pain
□ Mid-back pain
□ Joint pain
□ Colds
□ Earache
□ Ringing of the ears
□ Pain over stomach
□ Trouble controlling urine
□ Urgency to urinate
□ Swelling of ankles
□ Chest pain
□ Difficulty breathing
□ Multiple sclerosis
□ Pacemaker
□ Rheumatic fever

Please list any medication you are currently taking and why: (Females, please include birth control)
_______________________________________________________________________________.
_______________________________________________________________________________.
_______________________________________________________________________________.

**Chief Complaint**

1. Where do you hurt?______________________________________________________.
_______________________________________________________________________________.
_______________________________________________________________________________.
2. Do you have any numbness, tingling or weakness in your arms or legs? If so, please specify.______________.
_______________________________________________________________________________.
_______________________________________________________________________________.
3. When did your current symptoms appear?___________________________________.
4. Was there an event that caused or is related to your pain/symptoms?__________________.
_______________________________________________________________________________.
5. How often do you have symptoms, are they constant throughout the day or intermittent?__________.
_______________________________________________________________________________.
6. Have you had this in the past?_______________________________________________.
7. Please describe your pain (sharp, dull, shooting, etc.).___________________________.
_______________________________________________________________________________.
8. Please rate your pain 0-10 (0-best,10-worse).__________________________________.
9. Please check the box that best describes whether your pain or symptoms are affecting your daily activities.

| Activity | Normal | Somewhat limited | Severely limited |
|---|---|---|---|
| Lifting | □ | □ | □ |
| Bending | □ | □ | □ |
| Standing | □ | □ | □ |
| Walking | □ | □ | □ |
| Sitting | □ | □ | □ |
| Climbing stairs | □ | □ | □ |
| Running | □ | □ | □ |
| Resting in bed | □ | □ | □ |

**(please continue to next page)**

# FOOTHILS CHIROPRACTIC HEALTH CENTER
# PATIENT INTAKE

| Activity | Normal | Somewhat limited | Severely limited |
|---|---|---|---|
| Computer work/typing | ☐ | ☐ | ☐ |
| Household activities | ☐ | ☐ | ☐ |
| Recreational activities | ☐ | ☐ | ☐ |
| Other (list below) | ☐ | ☐ | ☐ |

________________________________________.

1. Are there positions or anything you do that can make symptoms better or worse?
________________________________________.
________________________________________.
2. Are there any other symptoms?________________________.
________________________________________.
3. Have you ever been x-rayed/imaging, why, where?____________________.
________________________________________.
4. Have you had any serious illnesses?________________________.
________________________________________.
5. Have you had previous Chiropractic Care?________________________.
6. Describe your typical diet.________________________.
________________________________________.
7. How many hours of sleep per night to you get?________________________.
________________________________________.
8. What is your level of stress (none, mild, moderate, severe, etc.)?____________________.
9. Have you had any joint replacements, a pace maker, or any other surgical procedures?____________________.
________________________________________.
10. Have you ever been diagnosed with osteoporosis or osteopenia?____________________.

**Past Health History**

| Have you... | Yes | No | If yes, briefly explain |
|---|---|---|---|
| ... been hospitalized in the last 5 years? | ☐ | ☐ | ____________________. |
| ... had any broken bones? | ☐ | ☐ | ____________________. |
| ... had any strains or sprains? | ☐ | ☐ | ____________________. |
| ... ever used orthotics? | ☐ | ☐ | ____________________. |
| Do you take any vitamins, minerals, or herbs? | ☐ | ☐ | ____________________. |

________________________________________.

How is most of your day spent? ☐ standing ☐ sitting ☐ other:____________________.
How old is your mattress?________________________.
When was your last physical exam?________________________.

| **Habits** | none | light | mod. | heavy |
|---|---|---|---|---|
| Alcohol | ☐ | ☐ | ☐ | ☐ |
| Coffee | ☐ | ☐ | ☐ | ☐ |
| Tobacco | ☐ | ☐ | ☐ | ☐ |
| Drugs | ☐ | ☐ | ☐ | ☐ |
| Exercise | ☐ | ☐ | ☐ | ☐ |
| Sleep | ☐ | ☐ | ☐ | ☐ |
| Soft drinks | ☐ | ☐ | ☐ | ☐ |
| Salty foods | ☐ | ☐ | ☐ | ☐ |
| Water | ☐ | ☐ | ☐ | ☐ |
| Sugar | ☐ | ☐ | ☐ | ☐ |

**Family history: if any blood relative has had any of the following conditions, please check and indicate which relative(s).**

☐ Arthritis____________________.
☐ Cancer____________________.
☐ Diabetes____________________.
☐ Osteoporosis____________________.
☐ Stroke____________________.
☐ Thyroid disease____________________.

**Do you have any other health issues or concerns that our staff should be aware of?**____________________.
________________________________________.

**Patient Signature:**______________________________. **Date:**____________________.

# FOOTHILLS CHIROPRACTIC HEALTH CENTER

# INFORMED CONSENT OF CARE

You are the decision maker for your health care. Part of our role as care providers is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, improving neurological function and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement, of symptoms, burns and/or scarring from electrical stimulation, bleeding from acupuncture needles, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery which may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that a chiropractic adjustment does NOT cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissection have been associated with over 72 everyday activities such as sneezing, driving and playing tennis. Arterial dissections occur in 3-4 out of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headaches. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and a stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use for major GI events of the entire (upper and lower) GI tract was 1,219 events per one million persons each year with a risk of death being estimated at 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include but are not limited to: self-administered care, over the counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about this content, and by signing below I agree not to hold Foothills Chiropractic Health Center Liable if a complication arises /occurs due to a treatment. I agree with current or future recommendations to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care, for all providers in this office for my present condition, and for any future condition(s) for which I seek chiropractic care for this office.

**Patient Name:**______________________________. **Signature:**______________________________. **Date:**__________.

**Parent or Guardian:**__________________________. **Signature:**______________________________. **Date:**__________.

**Witness Name:**______________________________. **Signature:**______________________________. **Date:**__________.

**FOOTHILLS CHIROPRACTIC HEALTH CENTER**

**PAYMENT OPTIONS**
**(Please Initial one option)**

__________1. Direct Payment Plan.

Pay cash, check or credit at the time or before the time of your visit. Your insurance will not be billed, business is strictly between you and Foothills Chiropractic Health Center LLC (FHCH, LLC). You will receive reduced rates because of the reduction of overhead expenses.

__________2. Insurance Payment Plan.

FCHC, LLC handles all billing, reports and correspondence with your insurance company directly. Your insurance company will pay us for their portion of the billed amount and you will be responsible for your deductible co-payments and co-insurance.

Foothills Chiropractic Health Center LLC, always verifies your coverage before accepting the responsibility of billing your insurance company and reserves the right, as a business decision, not to accept certain companies. At the time of verification, if your company is accepted, they will dictate your deductible and percentage of payment so that proper charges to the patient can be determined. However, the insurance company payments do not always reflect the amount dictated during the center's verification of your coverage. If this occurs, Colorado Insurance Regulations require FCHC, LLC to bill the patient for the remaining amount. It is the intention of FCHC, LLC to verify the proper coverage before accepting assignment of your case with your insurance company.

**ALL PRICES ARE SUBJECT TO CHANGE WITHOUT NOTICE.**

**Patient Name:** ______________________________________________

**Patient Signature:** ___________________________________________

**Date:** _______________________________________________________

**FOOTHILLS CHIROPRACTIC HEALTH CENTER**
**(Please choose only one of the following)**

## INSURANCE PATIENTS ONLY:

### AUTHORIZAION TO RELEASE INFORMATION TO INSURANCE COMPANY

I authorize Foothills Chiropractic Health Center to release information to insurance companies for the purpose of submitting claims for treatment by the providers in the practice. Only information required to adjudicate claims will be released. This may or may not include my medical record chart. This authorization includes any insurance information that I may have given Foothills Chiropractic Health Center. My signature below acknowledges and grants my permission for my insurance company to send reimbursement to Foothills Chiropractic Health Center.

| ____________________ | ____________________ | __________ |
|---|---|---|
| **Print your name** | **Signature** | **Date** |

## SELF-PAY PATIENTS ONLY:

### HEALTH INSURANCE WAIVER

By signing below I acknowledge my decision to be a self-pay patient at Foothills Chiropractic. I am wavering the use of my health insurance benefits, either because chiropractic services are not covered by my insurance or for personal preference. I understand that Foothills Chiropractic will not be responsible for any insurance claim submissions on my behalf.

If I decide to use my health insurance in the future, I agree that claim submission will not be back dated and will begin on the date that I decide to begin using my health insurance for chiropractic treatment.

| ____________________ | ____________________ | __________ |
|---|---|---|
| **Print your name** | **Signature** | **Date** |

**FOOTHILLS CHIROPRACTIC HEALTH CENTER**

**PATIENT GOWNING POLICY**

For certain conditions, it may be necessary to observe the part of your body that you are complaining about as well as surrounding areas. Certain conditions may have a skin rash, tissue bruising and/or discoloration or a cutaneous or subcutaneous tumor or cancer. If these are missed for failure to observe the complaint area, this could lead to misdiagnosis and unnecessary harm to your health.

Certain treatment procedures at Foothills Chiropractic may also require access to certain parts of your body. These procedures are not limited to, but may include acupuncture, ultrasound, electrical stimulation, massage, etc.

Therefore, we may request that you wear a patient gown for various conditions where an area of complaint may not be clearly visible without inspection, or the treatment area is not accessible without a gown. You need only remove your street clothes. Undergarments may remain in place. For lower back and lower extremity pain, we ask that you remove your pants/skirt to access the area of complaint. For subsequent treatments, you may be asked to use a gown and bring loose fitting clothes or shorts with you. Most of the time at Foothills Chiropractic we will be treating you in your street clothes and gowning will not be required. Keep in mind that if you gown or choose to remain in your street clothes, wrinkling and soiling of clothes from contact with gels, oils, etc., may be unavoidable for certain treatment procedures.

Our office wants you to feel comfortable with your care at all times. We respect issues of patient modesty. Your comfort and dignity are of the utmost importance to us. Please feel free to discuss any of this further with our doctors or staff. By signing this document you acknowledge that you understand why a gown would be suggested, and you are giving consent to Foothills Chiropractic gowning procedures. Please remember, you can always choose not to gown at any time for any reason.

______________________________ ____________________

**Patient Signature** **Date**