Belmar Chiropractic

Patient Intake Record

Please complete the following so that we may create your patient record and best serve your needs.

Name: _____ Todays Date: _____

Nickname: _____ Age _____ Male/Female (circle one)

Street Address: _____Unit/Apt _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Cell: (_____)_____

Work Phone (_____)_____ Date of Birth: (mm/dd/yyyy) ___/___/____

Email: _____

Best way to contact you (choose one of the above) _____

Occupation: _____ Employers Name: _____

Single / Married / Divorced / Widowed Spouses Name: _____

Number of Children and Ages ***Previous Chiropractic Care?***

Name _____ Age _____ Yes___ No___ Reason _____

Name _____ Age _____ Yes___ No___ Reason _____

Name _____ Age _____ Yes___ No___ Reason _____

Name _____ Age _____ Yes___ No___ Reason _____

Who may we thank for referring you? _____

In case of emergency, contact: _____

You deserve to be healthy. When you were conceived, you were given the blue-prints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal quickly and live the quality lifestyle you deserve.

1057 S. Wadsworth Blvd. Suite 40 Lakewood, CO. 80226
Phone: 303.233.1236 Fax: 303.233.1084 DrRick@BelmarChiro.com
GO CHIROPRACTIC
SDG

Belmar Chiropractic Health Profile

Name:_____ Date:_____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity:	Rate of Severity 1=mild 10=unbearable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5._____	_____	_____	_____	_____	_____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR? _____MEDICAL DOCTOR? _____OTHER_____

WHO AND WHEN? _____

CIRCLE ALL CURRENT PROBLEMS YOU ARE EXPERIENCING

ADD/ADHD	EAR INFECTION	LOW BACK PAIN	STOMACH DISORDERS
ALLERGIES	EPILEPSY	LUPUS	THROAT ISSUES
ANXIETY	FATIGUE	MENSTRUAL DISORDER	THYROID PROBLEMS
ARM PAIN	FIBROMYALGIA	MID BACK PAIN	TINNITUS
ASTHMA	GASTRIC REFLUX	MIGRAINES	TMJ ISSUES (Jaw)
BALANCE ISSUES	HEADACHES	NAUSEA	ULCERS
BLADDER PROBLEMS	HEART DISORDERS	NECK PAIN	VERTIGO
BREATHING PROBLEMS	HIGH BLOOD PRESSURE	NERVOUSNESS	VISION ISSUES/CHANGES
CHEST PAIN	HIP PAIN	NUMBNESS IN ARMS	OTHER_____
CHRONIC FATIGUE	INFERTILITY	NUMBNESS IN FEET	_____
CHRONIC SINUS	IRRITABLE BOWEL	NUMBNESS IN HANDS	_____
DEPRESSION	KNEE PAIN	NUMBNESS IN LEGS	
DISC PROBLEM	KIDNEY PROBLEMS	SCIATICA	
DIZZINESS	LEG PAINS	SLEEP ISSUES	

STROKE **CANCER** HEART DISEASE **SPINAL SURGERY** SEIZURES **SPINAL BONE FRACTURE** SCOLIOSIS **DIABETES**

For Office Use

Anterior Head	*R L ____inch*	*Care Plan*	*C spine ROM*	*F E RLF LLF RR LR*		*C 0 1 2 3 4 5 6 7*
High Shoulder	*R L ____inch*		*T spine ROM*	*F E RLF LLF RR LR*		*T 1 2 3 4 5 6 7 8 9 10 11 12*
Hip	*R L ____inch*		*L Spine ROM*	*F E RLF LLF RR LR*		*L 1 2 3 4 5 BP RSi LSi*
Short Leg	*R L ____inch*		*Arm Shoulder Leg*			

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Name:_____ Date:_____

Have you been under drug and medical care? _____

What medications are you taking? _____

How Long? _____ Have you had surgery? _____ What? _____

When?_____

What side effects have you experienced from the drugs and surgery? _____

_____

When was your last auto accident?_____

Have you ever been knocked unconscious? YES / NO

If yes, please describe:_____

Other Trauma:_____

_____

Social History:

The following questions are pertinent to your health history, give the doctor a more complete picture of overall health status and will help with directing treatment.

Are you currently engaged in an exercise program? ____ Yes ____No

If YES, please describe what you currently do for exercise. Include time and frequency per week:

_____

_____

_____

Please list a few of your personal interests, hobbies or sports (we can use these to track the progress of your functional status):

_____

_____

_____

What is your sleep pattern like? Do you sleep soundly, toss and turn, wake several times a night, stay awake for hours… How many hours of sleep do you get regularly?

_____

_____

_____

Do you smoke? ____ Yes ____No If YES, how many packs per day for how many years? _____

How many alcoholic drinks to you consume per week?_____

Beer? ____ Wine? _____ Hard Alcohol / Mixed drinks? _____

Name:_____ Date:_____

How would you rate your health?

Constant Pain/Suffering Comfortable Living Optimally

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Where would you like to be?

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

What are your stress factors and what is your level of stress today (10 is the worst)?

_____

_____

_____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

Your oldest grandparent on record lived to the age of _____.

❒ Still living ❒ Deceased

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible. Please review the Active Life Plan Explanations prior to your Chiropractic Report so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to (Please check all that apply)

❒ Feel better quickly
❒ Have a healthier spine and nervous system
❒ Live a healthier lifestyle

_____ _____

Signature Date

-- Thank you ***very*** much for taking the time to answer these questions! –

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Office Fee Schedule and Financial Policy

Service	Fees
Initial Exam with Computer Scans	$47
Adjustment	$55
Auriculotherapy (per session)	$75
X-Rays (per view)	N/A
Periodic Dynamic Exam	$25

Financial Policy and Active Life Plans

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you arrange an *Active Life Plan* in advance. These plans are designed to be the most cost effective way to keep you and your family as healthy as possible. They include your Crisis Care, Critical Transition, and Lifestyle Care Options. Details of these plans will be discussed with you during your Chiropractic Report. Please read the following:

Care packages are available for certain circumstances.

- If you are participating in Crisis Care, Critical Transition, or Lifestyle Care, you may request a receipt for tax purposes or a Health Savings Account (HSA) indicating the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts.

  If a special situation arises, such as an auto accident or a worker's compensation injury, a new examination will need to be performed and you will be charged our regular fees until the claim is settled. We will help you get reimbursed as quickly as possible on these claims.

I, (name) _____ have read and I understand the above policies.

_____

Patient signature Date

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INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC CARE, LIKE ALL FORMS OF HEALTH CARE WHILE OFFERING CONSIDERABLE BENEFITS MAY ALSO PROVIDE SOME LEVEL OF RISK. THIS LEVEL OF RISK IS MOST OFTEN VERY MINIMAL, YET IN RARE CASES, INJURY HAS BEEN ASSOCIATED WITH CHIROPRACTIC CARE. THE TYPES OF COMPLICATIONS THAT HAVE BEEN REPORTED SECONDARY TO CHIROPRACTIC CARE INCLUDE: SPRAIN/STRAIN INJURIES, IRRITATION OF A DISC CONDITION, AND RARELY, FRACTURES.

PRIOR TO RECEIVING CHIROPRACTIC CARE IN THIS CHIROPRACTIC OFFICE, A HEALTH HISTORY AND PHYSICAL EXAMINATION WILL BE COMPLETED. THESE PROCEDURES ARE PERFORMED TO ASSESS YOUR SPECIFIC CONDITIONS, YOUR OVERALL HEALTH AND IN PARTICULAR YOUR SPINAL HEALTH. THESE PROCEDURES WILL ASSIST US IN DETERMINING IF CHIROPRACTIC CARE IS NEEDED, OR IF ANY FURTHER EXAMINATIONS OR STUDIES ARE NEEDED. IN ADDITION, THEY WILL HELP US DETERMINE IF THERE IS ANY REASON TO MODIFY YOUR CARE OR PROVIDE YOU WITH A REFERRAL TO ANOTHER HEALTH CARE PROVIDER. ALL RELEVANT FINDINGS WILL BE REPORTED TO YOU ALONG WITH A CARE PLAN PRIOR TO BEGINNING CARE.

I UNDERSTAND AND ACCEPT THAT THERE ARE RISKS ASSOCIATED WITH CHIROPRACTIC CARE AND GIVE CONSENT TO THE EXAMINATION THAT THE DOCTOR DEEMS NECESSARY AND THE CHIROPRACTIC CARE, INCLUDING SPINAL ADJUSTMENTS, AS REPORTED FOLLOWING MY ASSESSMENT.

_____

PRINT NAME

_____ _____

SIGNATURE DATE

IF PRACTICE MEMBER IS A MINOR/CHILD, PARENT OR GUARDIAN MUST SIGN BELOW

_____ _____

SIGNATURE OF PRACTICE MEMBER (PATIENT) OR GUARDIAN DATE

_____

RELATIONSHIP TO MINOR/CHILD

_____ _____

WITNESS SIGNATURE (OFFICE STAFF) DATE

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PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEA LTHCARE OPERATIONS

By signing this Consent, I hereby acknowledge and agree as follows:

1. The Privacy Notice issued by Belmar Chiropractic, Rick Kirkpatrick, D.C. (the "Practice") has been offered to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; and c) email to me at the address provided by me.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all ***future*** transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse treatment.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice or I revoke consent at any time, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (Printed) Signature of Individual

This form was created by the Colorado Chiropractic Association and is distributed with their permission.

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of force to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. (Defined by the World Health Organization)

Vertebral Subluxation: A misalignment of one or more of the 24 moveable vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses; resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate (inborn), wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

(Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

(Signature) (Date)

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