**Welcome to our Office:**

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

**Consultation & Exam**

To begin today's visit, you will be asked to complete confidential health information for us to discuss with you. To learn more about your condition, we will perform preliminary examinations which may include a physical examination and laboratory tests.

If we believe that we may be able to help you, we will give you a report of our findings and recommend a treatment plan. As you advance through treatment, periodic progress evaluations will measure and compare your improvement. We will always inform you of associated fees before we perform any procedure or service.

I understand and agree to the above information:

Date_____

Print Name-Patient _____

Signature-Patient or Guardian_____

**DOCTORS USE ONLY:**

**HT:** **WT:** **O2:** **HR:** **BP:**

# PATIENT CASE HISTORY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____

Occupation: _____Date of Birth: _____

Social Security #: _____-_____-_____ Gender: Male - Female

Marital Status: _____ Spouse Name: _____

List any **Allergies**:

□ Animals □ Aspirin □ Bees □ Chocolate □ Dairy □ Dust □ Eggs□ Latex □ Molds □ Penicillin

□ Ragweed/Pollen □ Rubber □ Seasonal Allergies □ Shellfish □ Soaps □ Wheat □ X-Ray Dye

□ Other: _____ Reactions:_____

_____

List any **Surgeries**:

□ Back □ Brain □ Elbow □ Foot □ Hip □ Knee □ Neck □ Neurological □ Shoulder □ Wrist

□ C-Sect □ Other: _____

List **ALL Past and Present Medical Conditions:**

□ Ankle Pain □ Arm Pain □ Arthritis □ Asthma □ Back Pain □ Broken Bones □ Cancer □ Chest Pain

□ Depression □ Diabetes □ Dizziness □ Elbow Pain □ Epilepsy □ Eye/Vision Problems □ Fainting

□ Fatigue □ Foot Pain □ Genetic Spinal Condition □ Hand Pain □ Headaches □ Hearing Problems

□ Hepatitis □ High Blood Pressure □ Hip Pain □ HIV □ Jaw Pain □ Joint Stiffness □ Knee Pain □ Leg Pain

□ Mid-Back Pain □ Minor Heart Problem □ Multiple Sclerosis □ Neck Pain □ Neurological Problems

□ Pacemaker □ Parkinson's □ Polio □ Prostate Problems □ Shoulder Pain □ Significant Weight Change

□ Spinal Cord Injury □ Sprain/Strain □ Stroke/Heart Attack □ Other:_____

**Women Only:**

□ Menstrual Problems □Fatigue □ Currently Pregnant □ Weight Change □ Birth Control □ Hair Loss

Age of first menstrual period:_____ LMP _____

**Active Medications** you are taking:

1. _____
2. _____
3. _____
4. _____

**Supplements** you are taking:

1. _____
2. _____
3. _____
4. _____

**Medication Allergies:**

_____

_____

_____

List your **Family History**:

Example: Grandmother – High blood pressure

_____

_____

_____

Have you had any auto or other accidents? □ No □Yes

Example: falls, horse accident, crashes, trips, snowmobiling, atv, head injury etc.

Describe: _____

Date of last physical examination: _____

Do you smoke? □ No □ Yes how many per day? _____

Do you drink alcohol? □ No □ Yes how many per day? _____

Do you drink caffeine? □ No □ Yes how many per day? _____

Do you exercise? □ No □Yes (what forms and how often):_____

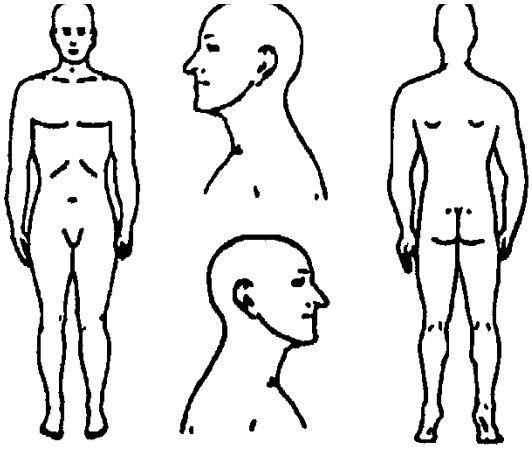
Have you ever had chiropractic care? □ No □ Yes

When? _____Why? _____

Were X-rays taken? □ No □ Yes

When was your last adjustment? _____

*PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW*



Main reason for consulting the office:

- □ Become pain free
- □ Explanation of my condition
- □ Learn how to care for my condition
- □ Reduce symptoms
- □ Resume normal activity level

What is your **Primary** complaint? _____

Date problem began? _____

How did this problem begin (falling, lifting, etc.)?

_____

Have you had this condition in the past? YES - NO

How is your condition changing? □ GETTING BETTER □ GETTING WORSE

□ NOT CHANGING

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving? (0= no effect and 10= no possible activities)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

**Intensity:** □Minimum □Mild □Moderate □Severe □Unbearable □None

**Describe the nature of your symptoms**:

□ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling □ Radiating Pain □ Tightness

□ Stabbing □ Throbbing □ Other: _____

What activities aggravate your condition (working, exercise, etc.)?

_____

What makes your pain better (ice, heat, massage, etc.)?

_____

How often do you experience your symptoms?

□Constantly (76-100% of the day) □Frequently (51-75% of the day)

□Occasionally (26-50% of the day) □Intermittently (0-25% of the day)

What is your **SECOND** complaint? _____

Date problem began? _____

How did this problem begin (falling, lifting, etc.)?

_____

Have you had this condition in the past? YES - NO

How is your condition changing? □ GETTING BETTER □ GETTING WORSE □ NOT CHANGING

Please rate your pain on a scale of 1 to 10 (0= no pain and 10= excruciating pain)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?

(0= no effect and 10= no possible activities)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

**Intensity:** □Minimum □Mild □Moderate □Severe □Unbearable □None

**Describe the nature of your symptoms:** □ Sharp □ Dull □ Numb □ Burning □ Shooting □ Tingling

□ Radiating Pain □ Tightness □ Stabbing □ Throbbing

□ Other: _____

What activities aggravate your condition (working, exercise, etc.)?

_____

What makes your pain better (ice, heat, massage, etc.)?

_____

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)

□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

**How did you hear about us? _____**

**Are you or your spouse: Military, Police, Fire, Rescue or Retired Military? (Circle all that apply)**

Name:_____Date:_____

**Race:**

[] American Indian or Alaska Native
[] Asian
[] Black or African American
[] Native Hawaiian or Other Pacific Islander
[] White
[] Patient Declined to Answer

**Ethnicity:**

[] Hispanic or Latino
[] Not Hispanic or Latino
[] Patient Declined to Answer

**Smoking Status**:

[] Current Every Day Smoker
[] Current Some Day Smoker
[] Former Smoker
[] Never Smoker

**Preferred Language:**

_____

# Consent for Photography

I consent to have my photo (or child/individual to whom I provide guardianship) to be taken by the staff at 4-Corners Chiropractic as described below.

I understand that the photograph, digital, and other images may be recorded to document and assist with me, my child/individual to whom I provide guardianship care and security. I understand that 4-Corners Chiropractic in Cortez will own these images, but that I will be allowed access to view them or to obtain copies of them at a reasonable cost. Other than for treatment, education, and security, images that identify me (or child/individual to whom I provide guardianship) will be released and/or used outside the organization only upon written authorization from me or the patient representative.

If the images are to be taken for any purpose other than for treatment, education, or patient security. The purpose(s) must be stated: NONE

I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

I release and hold harmless 4-Corners Chiropractic, Cortez Colorado, staff and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of the photograph or other image.

By signing below, I am indicating that I have read and understand the "Consent for Photography" form.

**Print Patient Name:** _____

**Signature Patient or Legal Guardian:** _____

# INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and cost vertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the chiropractic treatment recommended.

Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Jeremy W Rosenbaugh, DC  321 E. North ST. Cortez Colorado 81321

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

_____

Signature of Patient or Patient Representative (if minor or physically incapacitated)

# APPOINTMENT POLICIES

When scheduling your appointment, please keep in mind this appointment is for **you…**if you need another person that is with you, (child, spouse, friend)etc. to be seen by the Dr., please see the receptionist to make another appointment for that person.

**LATE:** Late arrivals are considered a cancellation. If you are 5 or more minutes late for your scheduled appointment, you may need to reschedule. Being late translates to insufficient time to perform the necessary treatment.

**CANCELLATIONS:** Cancellations require 1 hour minimum notice (24 hr. preferred)

There will be a **$30.00** fee charged for all **LATE, NO SHOW** and **MISSED** appointments. Cancellations that have given 1 hour notice will not be charged.

If you are one of our high school sports patients, penalty for any of the above will result in the loss of discounted care for the remainder of the season.

There may be times when we run late. This is due to some unforeseen Patient clinical need that we must accommodate. We respect our patient's time and will do all we can to be on schedule.

Thank you very much for your understanding.

Date: _____

Patient Name: _____

Patient/Guardian Signature: _____

**Name of Patient:** _____

**Patient Date of Birth:** _____

# Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of 11/21/11

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

## Documentation of Good Faith Efforts To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

The patient presented to the office/hospital on [insert date] and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:

  _____

- ☐ The patient had a medical emergency, and an attempt to obtain the Acknowledgment will be made at the next available opportunity.
- ☐ Other reason (describe below):

  _____

Signature of Employee Completing Form:

_____ Date Signed: _____