Rockrimmon Chiropractic

425 W. Rockrimmon Blvd. Suite 100, Colorado Springs, CO 80919

Patient Name:_____ Date: _____ Email: _____

SS #/SIN:_____ DOB:_____ □ Male □Female Phone: _____

Check appropriate Box**:** □Minor □Single □Married □Divorced □Widowed □Separated

Are you: □Active Military □Ministry □Medicare □Medicaid

Patient's Address: _____City: _____ State:_____ Zip:_____

Employer Name: _____

Spouse or Patient's Guardian name:_____ Spouse's Employer:_____

Whom may we thank for referring you?_____

Person to contact in case of an emergency:_____ Phone:_____

Responsible Party

Name of The Person responsible for this account: _____Relationship to Patient: _____

Address: _____ Cell Phone: _____

Home phone:_____ SS #/SIN: _____ Date of Birth: _____

Is the person currently a patient at our office? □ Yes □ No

Do you have any Medical insurance? □ Yes □ No if yes, complete the following:

Name of the insured:_____ Relationship to patient:_____

Insurance Company:_____ ID #:_____

Current Health Condition

Chief Complaint (Why are you here): _____

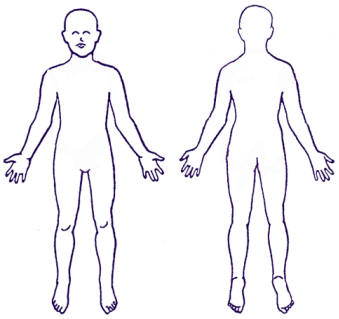
_____

When did this condition begin? _____ Has it occurred before? Yes / No

Is this condition _____ Auto Related _____Work Related _____Other _____ No Injury

Explain: _____

_____



Mark where problem exists

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication: (include nonprescription)

_____

_____

Are you taking any medications for acid indigestion? O yes O no if yes what type: _____

Supplements: _____

Patient Social History:

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of Drugs Never: _____ Type/Frequency:_____

Excessive Exposure

At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

AIDS & HIV……NO YES
Chicken Pox……NO YES
Diphtheria……NO YES
Hepatitis……NO YES
Infectious Mono……NO YES
Measles……NO YES
Mumps……NO YES
Pneumonia……NO YES
Polio……NO YES
Rheumatic Fever……NO YES
Scarlet Fever……NO YES
Small pox……NO YES
Tuberculosis……NO YES
Venereal Disease……NO YES

Whooping Cough……NO YES
Cancer……NO YES
Anemia……NO YES
Bleeding Tendency……NO YES
Blood Plasma
Transfusion……NO YES
Chest Pain/Angina……NO YES
Heart Attack……NO YES
Heart Murmur……NO YES
High Blood Pressure……NO YES
Low Blood Pressure……NO YES
Mitral Valve
Prolapse……NO YES
Diabetes……NO YES

Thyroid Disease……NO YES
Frequent Diarrhea……NO YES
Gallbladder Dz……NO YES
Heartburn……NO YES
Hemorrhoids……NO YES
Hernia……NO YES
Ulcer……NO YES
Hives or Eczema……NO YES
Arthritis……NO YES
Back Trouble……NO YES
Epilepsy……NO YES
Migraine Headache……NO YES
Stroke……NO YES
Glaucoma……NO YES

Kidney Disease……NO YES
Asthma……NO YES
Bronchitis……NO YES
Bladder Infection……NO YES
Loss of Urine……NO YES
Date of Last Chest X-Ray
_____
Any Other Disease……NO YES
List:_____
_____
_____
_____
_____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Hay Fever	1 2 3 4 5
Hoarseness	1 2 3 4 5
Itching	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Sore throat	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Ankle/Foot Pain	1 2 3 4 5
Arthritis	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Hip Pain	1 2 3 4 5
Joint Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Muscle Aches	1 2 3 4 5
Neck Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5

Neurological

Dizziness	1 2 3 4 5
Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Numbness	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5
Tingling	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5

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Assignment of Benefits

Self Pay: It is my responsibility to notify the staff how I will be paying for services rendered. I understand that, if there is no third party (insurance) involved, I am responsible for full payment at the time of service. If a third party does become involved, I understand it is my responsibility to notify the office staff of this change. I further understand it is not the policy of Rockrimmon Chiropractic to bill for services previously rendered.
Insurance/Contract-Services/Third Party: It is my responsibility to know my insurance benefits and plan parameters for chiropractic care, and I will be responsible for contacting my insurance company myself, should I have any questions. I authorize and request my insurance company to make payment directly to Rockrimmon Chiropractic unless other arrangements have been made. We will not become involved in disputes with your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, “usual and customary” charges, etc., other than to supply factual information. Remember, your insurance contract is between you and your insurance company.

Disclosure of Health Care Information (HIPAA)

I understand that my personal health information is private and confidential. The HIPAA Privacy Rule gives individuals the right to request restrictions on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of that a communication of PHI be made by alternative means. The providers and staff at Rockrimmon Chiropractic, LLC, work hard to ensure the privacy and confidentiality of my personal health information. I understand that providers and staff at Rockrimmon Chiropractic work to disclose to me personal health information to help provide health care, handle billing and information, and to take care of other health operations. I understand that I have the right to ask my provider to limit how my personal information is used or disclosed to carry out treatment, payment, or other health care operations.
I wish to be contacted in the following manner (Check all that apply):
( )By telephone _____ ( ) Work ( ) Cell ( ) Home
( ) It is OKAY to leave detailed message ( ) Message with call back number ONLY
( ) Written communication
( ) Okay to send mail to my home address
( ) Okay to send email to the following address _____

I hereby authorize Rockrimmon Chiropractic, LLC to provide clinical information or answer questions regarding my care with (Check all that apply):
Name: _____ Relation to client: _____Phone Number:_____
( ) Information regarding treatment ( ) Lab results ( ) Appointment Information
Name: _____ Relation to client: _____Phone Number:_____
( ) Information regarding treatment ( ) Lab results ( ) Appointment Information

Patient Name_____

Patient Signature_____ **Date** _____

Consent to Treat

I hereby request and consent to the performance of therapeutic exercise monitored by a rehabilitation technician, chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I can discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:
Adjustments: increased discomfort, fractures, disc injuries, strokes, dislocations and sprains.
*The primary techniques used by the doctors at Rockrimmon Chiropractic virtually eliminate the risk of fracture, dislocations, stroke, and disc injury – but we still have to say it.
Therapeutic Modalities and procedures: additional pain and discomfort.
Radiographs: ionizing radiation can be harmful to a fetus for those **who are pregnant or might be pregnant.**
Lab Draws: bleeding at site of draw, bruising, nausea and loss of consciousness

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I understand that if I request a private consultation with the doctor to discuss personal health matters, upon my request, this private room with the doctor and a staff member will be provided.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its 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 condition(s) for which I seek treatment.

Patient Name_____

Patient Signature_____ **Date** _____

Consent to evaluate and adjust a minor child

I, _____being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.
*In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

X_____

Signature **Printed Name** **Date**