Cornerstone Chiropractic

2525 W. 16th Street, Suite B · Greeley, CO 80634 · (970) 352-9277 · FAX (970) 352-9428

Date: _____ **Patient #**_____ *(office use only)* **Doctor:** Darin W. Busse, D.C.

Name: _____ SS#_____ Home Phone: _____

Address: _____City:_____ State: _____ Zip: _____

E-mail:_____ Cell Phone: _____

Age: _____ Birth Date: _____ Status: Married Single Widowed Divorced

Occupation: _____ Employer: _____

Employer's Address: _____ Office Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

How many children? _____ Names and ages of children: _____

_____

Name of Nearest Relative: _____ Address: _____ Phone: _____

Family Medical Doctor: _____

May we have your permission to update your medical doctor regarding your care at this office? _____

How were you referred to our office? _____

HISTORY OF PRESENT ILLNESS:

Chief Complaint - Purpose of this appointment: _____

Date symptoms appeared or accident happened: _____

Is this due to: Auto_____ Work_____ Other _____

Have you ever had the same or a similar condition? ❑ Yes ❑ No If yes, when and describe: _____

_____

Days lost from work: _____ Date of last physical examination: _____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having or have suffered from? (Place a √ by any conditions that apply to you)

____Broken or Fractured Bones	____Osteoarthritis	____Eating Disorder
____Circulatory Problems	____Epilepsy	____Alcoholism
____Rheumatoid Arthritis	____Pace Maker	____Drug Addiction
____Seizures/Convulsions	____Strokes	____HIV Positive
____A Congenital Disease	____Cancer	____Gall Bladder
____Excessive Bleeding	____Ruptures	____Depression
____High/Low Blood Pressure	____Coughing Blood	____Ulcers

Do you have a history of stroke or hypertension? _____

Have you had any major illnesses, injuries, falls, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? ❑ Yes ❑ No

If yes, describe: _____

What medications or drugs are you taking? _____

_____

Do you have any allergies to any medications? ❑Yes ❑No

If yes, describe: _____

Do you have any allergies of any kind? ❑Yes ❑No

If yes, describe: _____

Please list any other health problems you have, no matter how insignificant they may be:

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? _____ If so, how much per week? _____
Do you use any tobacco products? _____ Do you smoke? _____ If so, packs per day: _____
Do you take vitamin supplements? _____ If so, please list: _____
Do you consume caffeine? _____ If so, how much per day: _____
Do you exercise? _____If yes, what is the frequency and type of exercise? _____
What are your hobbies? _____
What percentage of time during the day (at home or at your job away from home) do you spend:
Lifting _____ Sitting _____ Bending _____ Working at a computer _____ Physical activity/exercise_____

FAMILY HISTORY:

Parents:
Father: (check one) living _____ deceased _____ Current age if still living: _____
Cause of death and age at death if deceased: _____

Mother: (check one) living _____ deceased _____ Current age if still living: _____
Cause of death and age at death if deceased: _____

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do?
If so, please list: _____

FAMILY DISEASES: indicate if a family member has/had with F, M, B, or S, (**F**ather, **M**other, **S**ister, **B**rother):

_____ Tuberculosis	_____ Cancer	_____ Mental Illness
_____ Diabetes	_____ Asthma	_____ Heart Disease
_____ Stroke	_____ Kidney Disease	_____ Lung Disease
_____ Arthritis	_____ Liver Disease	_____ Bowel/Bladder

Other (explain) _____

Please check any and all insurance coverage that may be applicable in this case**:**
❑Auto Accident ❑Worker's Compensation ❑Major Medical ❑Medicare ❑Medicare Supplement
❑Medical Savings Account or Flex Plans ❑Other

Name of Primary Insurance Company: _____
Name of Secondary Insurance Company (if any):_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____