Chiropractic Wellness Center
It's more than feeling better... it's being healthier.

New Patient Intake Form

Today's Date: _____ Name: _____ Birth Date: _____

What do you prefer to be called: _____ *Male / Female* (please circle) Your age: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Whom may we thank for referring you? _____

I would like to receive appointment reminders by: ____ Phone ____ Email ____ Text

If choosing "Text" please tell us you Phone Provider (Verizon, AT&T, etc.): _____

Employer: _____ How long employed: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Status: Minor Single Married Divorced/Separated Widowed *(please circle)*

Spouse's Name: _____ Children: yes no _____ *(If yes, how many?)*

Insurance *(Let us make a copy of your insurance card and you can skip this section)*

Company Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's ID #: _____ Group #: _____

Insured's Name: _____ Relation: _____

Insured's Date of Birth: _____ Insured's Employer: _____

Reason For Your Visit

The reason for your visit is a result of : Work Sports Auto Trauma Chronic *(please circle)*

Please explain what happened: _____

_____

_____

Please describe the location of your pain: _____

_____

_____

When did this begin? _____ Is this interfering with: work sleep daily routine *(please circle)*

Is your condition getting: better worse same *(please circle)*

Please explain: _____

_____

Have you had this or similar conditions before, if so, please explain: _____

_____

Have you received treatment for this condition any where else? yes no *(please circle)*

If yes, where: _____

Have you received treatment by a chiropractor before? yes no *(please circle)*

If yes, where: _____

In Event Of An Emergency

Who should we contact? _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Who is your Medical Doctor? _____ Phone: _____

Account Information *(Person ultimately responsible for account)*

Name: _____ Relation: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Health History

Do you have or ever had any of the following diseases or conditions?

___ Heart Attack
___ Stroke
___ Congenital Heart Defect
___ Alcohol/Drug Abuse
___ HIV+/AIDS
___ Frequent Neck Pain
___ Hi/Lo Blood Pressure
___ Severe/Frequent Headaches
___ Fainting/Seizures/Epilepsy
___ Diabetes
___ Tuberculosis
___ Lower Back Problems

___ Heart Surgery
___ Pacemaker
___ Mitral Valve Prolapse
___ STD
___ Shingles
___ Emphysema
___ Glaucoma
___ Psychiatric Problems
___ Kidney Problems
___ Sinus Problems
___ Difficulty Breathing
___ Artificial Bones/Joints

___ Heart Murmur
___ Artificial Valves
___ Hepatitis
___ Cancer
___ Anemia
___ Rheumatic Fever
___ Ulcers/Colitis
___ Asthma
___ Chemotherapy
___ Arthritis
___ Prostate
___ Endometriosis

Are you taking any of the following medications? Pain Killers (including Aspirin) Muscle Relaxers Stimulants Blood Thinners Tranquilizers Insulin Other(s) _____

Please list any other serious medical condition(s) you have or ever had: _____

_____

Please list anything you may be allergic to: _____

Please list previous surgeries/treatments with dates: _____

_____

Please list past serious accidents with dates: _____

_____

Family health history: _____

_____

Do you: Take nutritional supplements? yes no Exercise? yes no

Do you smoke? yes no How long? _____ How much? _____

What is the age of your mattress? _____ Is it comfortable? yes no

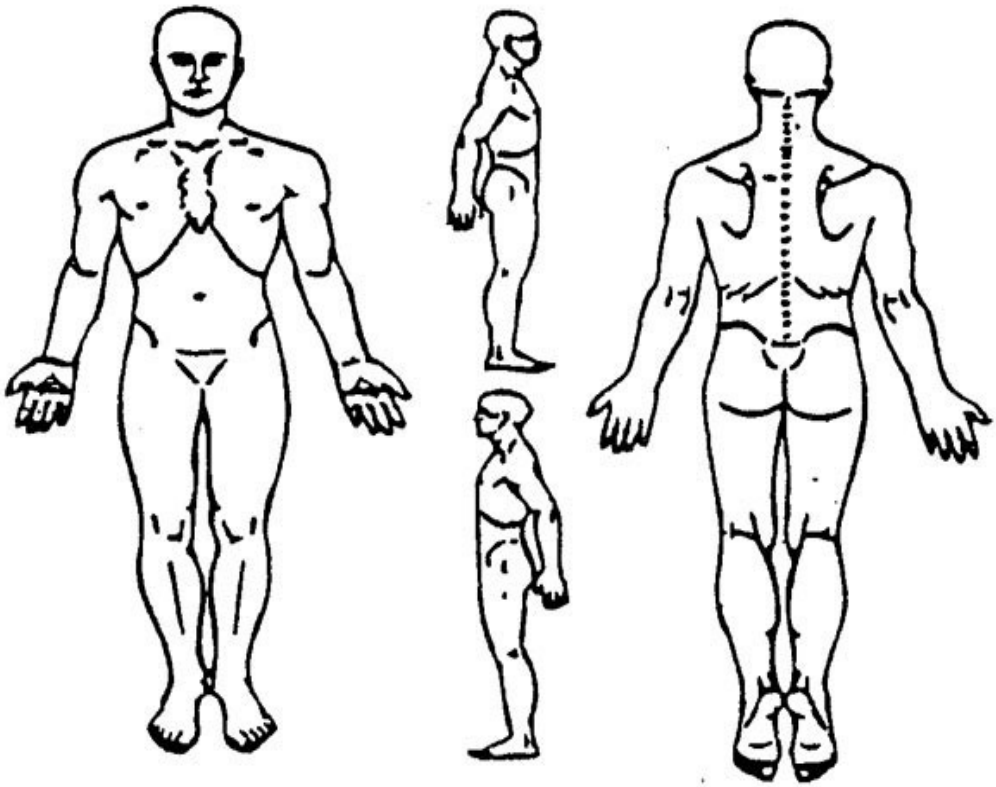
Women only: Do you use Birth Control? yes no Pregnant? yes no How many months? _____

Pain Chart

What is your current weight: _____ lbs., and height: _____ ft. _____ in.

Please mark the figure below with:

Muscle Spasm = M Burning = B Ache = A Numbness = N Pins & Needles = P
&
Number 1-10 (1 being *little to no pain* and 10 being *very painful*)



Informed Consent of Treatment, Payment, & Healthcare Operations for
Chiropractic Wellness Center, Inc.
4704 Harlan St., #510
Denver, CO 80212
303.463.0722

In this document, "I" and "my" refer to me, the patient, and "Chiropractor" refers to the Chiropractic Wellness Center and/or Dr. James Doran, his preceptor and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as "back-up" for the above named persons.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, acupuncture, low level light therapy, and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by Chiropractor. I have had an opportunity to discuss with Chiropractor and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on Chiropractor to exercise judgment during the course of the procedure which Chiropractor feels at the time, based upon the facts then known to him or her, is in my best interest.

Chiropractic treatment involves the science, philosophy, and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular, and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease, or condition as a result of treatment in this clinic. I understand that Chiropractor will use his or her hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click". It is my intention to rely on Chiropractor to exercise professional judgment during the course of any procedures, which he or she feels at the time are in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and Chiropractor's interpretation thereof, as well as the Chiropractor's judgment and expertise in working with like cases.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis, or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted at the above address. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have read, or 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 also authorize the provider and or managed care organization to release any information required to process insurance claims on my behalf. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. 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. I also authorize the provider and or managed care organization to release any information required to process insurance claims on my behalf and authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office). I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Name: _____ **Date:** _____
(printed)

Signature: _____ **Witness:** _____
Adult Patient, Parent/Guardian, or Spouse