Welcome to Colorado Springs Chiropractic
Patient and Contact Information & History – RE-EXAM

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Please fill out the following form in as much detail as possible. All your health information is kept confidential.

Name: _____ Today's Date: _____

Address: _____City: _____State:_____Zip:_____

Gender: Male Female Height: _____ Weight: _____ DOB: _____

Phone: _____ Home or Cell E-mail Address: _____

Emergency Contact Name: _____

Emergency Contact Relationship: _____ Phone: _____

Medication List: Please list the name of each current prescribed and over the counter medications, prescribed use, and any side effects/reactions.

Medication	Purpose of Taking Medication	Any Side Effects

Please initial below:

_____ Cancellation/No Show: If for any reason you need to cancel or reschedule an appointment, please notify our office within 24 hours to avoid a **$30 Cancellation Fee or $50 No Show Fee.**

_____ I consent to receive email and text messages from the practice at my number listed above. I understand that this request will apply to all future appointment reminders.

Doctors Notes:

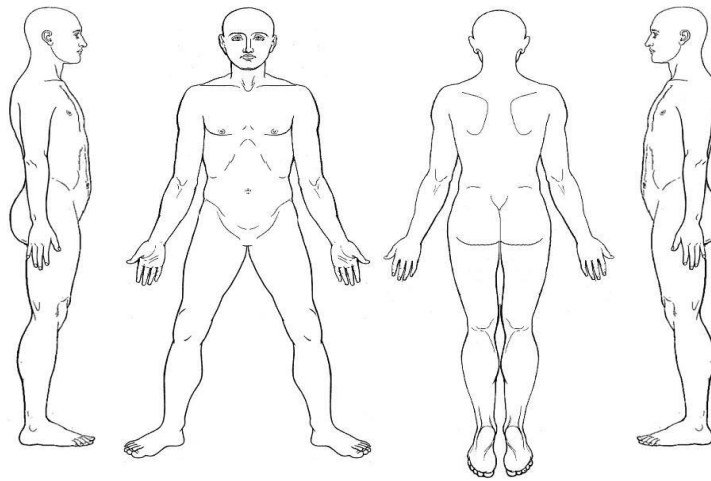
COLORADO SPRINGS CHIROPRACTIC

Pain Diagram & Visual Analog Scale

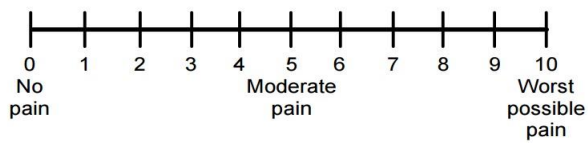
Please read carefully: Mark the areas on the diagram below that coincide with your pain. Include all the affected areas. Use as many individual symbols as you'd like to describe the pain intensity.

Indicate radiation of pain by drawing an arrow (⟶) from the origin of pain to where it stops. Use the appropriate symbol(s) listed below.

ACHING	NUMBNESS	PINS & NEEDLES
XXX XXX XXX	=== === ===	OOO OOO OOO
BURNING	**STABBING**	**THROBBING**
>>> >>> >>>	/// /// ///	+++ +++ +++



Please use the scale below to rate your pain over the past 24 hours.



NEUROLOGICAL & METABOLIC CASE HISTORY

What is your primary problem/symptom you are having? (Please be as specific as possible)

_____

_____

List other symptoms you are currently experiencing even if not related to complaint listed above:

_____

_____

Describe what you are feeling:

☐ Diffuse ☐ Dull ☐ Ache ☐ Sharp ☐ Burning ☐ Cramping

When & how did this problem/symptom begin?

_____

_____

Have you had this or similar conditions in the past? If yes, when?

_____

_____

What makes your condition worse?

_____

_____

What makes your condition better?

_____

_____

Do you experience **Numbness** or **Tingling**? If yes, where? (Does it radiate down the arm(s), back, leg(s), other?

_____

_____

Symptom Intensity:

☐ None/0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10/Unbearable

When you are awake, how often do you feel the symptoms? (0-100%)

☐ Never/0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%/All of the time

When do you experience this throughout the day?

☐ AM ☐ PM ☐ All Day

How many days per week do you experience your main complaint?

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Is your condition:

☐ Progressively Getting Worse ☐ Constant ☐ Comes & Goes

Have you had any treatment for this problem in the past? If yes, when/by whom? How did the previous methods work for you?

_____

_____

Are there any conditions that run in your family? If yes, what conditions and family members? (Please be detailed)

_____

_____

When was your last:

- Physical: _____
- Blood/Lab Work: _____
- X-Ray: _____
- MRI: _____

Surgical History: Please list the type, reason, and year of surgery.

_____

_____

_____

_____

_____

Doctor's Notes:

REVIEW OF SYSTEMS

Please **CIRLCE** any of the following conditions or complaints that you are experiencing.

Abnormal Bowel Movements	Diabetes: Type 2	Kidney Disease
AD/HD	Diarrhea	Leg Pain
Adrenal Disorder	Difficulty Swallowing	Liver Disease
Anxiety	Difficulty Hearing	Low Back Pain
Arthritis	Digestive Issues	Migraine
Asthma	Dizziness	Monovision Correction
Atypical Facial Pain	Double Vision	Multiple Sclerosis
Arm Pain	Dry Eyes	Neck Pain
Auto-Immune Condition	Dry Mount	Osteoporosis/Pena
Balance Problems	Dyslexia	Poor Digestion
Bladder Control	Ear Infections	Ringing in Ear(s)
Bleeding Disorder	Excessive Bloating	Regional Pain Syndrome (CRPS)
Blood Sugar Issues	Excessive Saliva	Rotator Cuff Issues
Blurred Vision	Excessive Tearing	Sensations of Spinning
Buzzing in Ear(s)	Facial Numbness	Shoulder Pain
Carpal Tunnel Cancer	Facial Weakness	Slurring Words
Celiac Disease	Fibromyalgia	Stroke/TIA
Changes in/Loss of Smell	Food Sensitivity	STI/STD
Changes in Sexual Function/Ability	Fusions (Spinal)	Sweaty Feet
Chest Pains	Gout	Sweaty Hands
Chronic Fatigue	Gall Bladder Issue	Thick Tongue Feeling
Cold Feet	Gluten Intolerant	Tinnitus
Cold Hands	Headache	Tremors
Colitis/Diverticulitis	Heart Disease	Trigeminal
Compression Fractures	Hepatitis: A B C	Neuralgia
Concussion	Herpes	TMJ
Connective Tissue	High Blood Pressure	Thyroid Issues
Constipation	Hip Replacement	Tuberculosis
COPD	HIV/AIDS	Tingling Burning Numbness in Hands/Feet
Dairy Intolerant	Immune Deficiency	Visual Change/Loss of Vision
Depression	Insomnia	Vertigo
Diabetes: Type 1	Joint Pain	None of the above

Please list any comments/concerns regarding information above:

_____

_____

_____

CHIROPRACTIC INFORMED CONSENT

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT: The primary treatment we use as a Doctor of Chiropractic is spinal manipulation therapy (SMT, CMT}. We will use this procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as you move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

THE MATERIAL RISKS INHERENT TO CHIROPRACTIC CARE: The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment. ----- The risks include: ● Temporary worsening of symptoms – Usually, an increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days. ● Skin irritation or burn – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar. ● Sprain or strain – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care. ● Rib fracture – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention. ● Injury or aggravation of a disc – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while. Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition. The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed. ● Stroke – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke. Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain. Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged, and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke. The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance, and brain function, as well as paralysis or death.

THE PROBABILITY OF THOSE RISKS OCCURRING: Statistically, Chiropractic Care has been demonstrated to be one of the safest of all healthcare practices. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I checked for during the raking of your history and examination. CVA has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur one in five million cervical adjustments. Two major studies (2008, 2015} showed there was no causation between CMT and CVA but rather the patient was already presenting with arterial dissection. The other complications are also generally described as rare.

THE AVAILABILITY & NATURE OF OTHER TREATMENT OPTIONS: Other treatment options for your condition may include: -Self-administered, over the counter (OTC) analgesics, ice, heat, or rest. -Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain killers. -Hospitalization/Surgery If you choose to use one of the above noted "other treatment" options, you should be aware that there are severe risks associated with these treatments. Many patients taking OTC NSAID's such as Ibuprofen and Acetaminophen are not aware that every year there are thousands of deaths associated with their use. No medicine should ever be taken without discussing their side effects and inherent statistical danger with their primary care physician or pharmacist. The PDR is also a good reference regarding pharmaceutical use.

THE RISKS & DANGER ATTENDANT TO REMAINING UNTREATED: Remaining untreated may create adhesions or scar tissue that can weaken the area and reduce mobility. Further joint degeneration may occur as well as the development of chronic pain syndromes. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

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

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 treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ Patient's Name: _____ Signature: _____

Signature of Parent or Guardian (if minor): _____

Dated:_____ Doctor's Name: _____ Signature: _____

FINANCIAL RESPONSIBILITY & HIPPA

INSURANCE: All services are rendered and charged to the patient receiving care and not to an insurance provider. Regardless of the insurance carrier, you are responsible for payment at the time services are rendered. You will be supplied with statements, reports, or any other documents that you need to receive reimbursement from a third party. Please be advised that some services we provide are not reimbursable by insurance companies (e.g., Heart Rate Variability HRV assessment). Please note that all services, supplements, and supplies are 100% nonrefundable.

COPAY, DEDUCTIBLES & CO-INSURANCE: All patients are responsible for their co-payments, deductibles, and past due balances at the time of service.

MISSED APPOINTMENTS: Many people benefit from care and therefore, appointment times are valued. With the exception of unexpected emergencies, we require that you notify us at least 24 hours in advance to avoid any appointment charges. Failure to do so will result in a $30-$50 no show/late cancellation fee being charged to the card on file for the appointment time that you reserved. This charge is the responsibility of you, the patient, and will not be reimbursed by an insurance policy.

RETURNED CHECKS: There will be a $25 service fee for any check returned for insufficient funds.

PLEASE NOTE THAT ANY BENEFIT INFORMATION FURNISHED IS NOT A GUARANTEE OF PAYMENT NOR A DETERMINATION OF MEDICAL NECESSITY AND FINAL CLAIM DETERMINATION WILL BE MADE UPON RECEIPT AND REVIEW OF THE CLAIM. THE PATIENT IS RESPONSIBLE FOR ALL BALANCES OUTSTANDING.

MEDICAL INFORMATION RELEASE FORM (HIPPA RELEASE FORM)

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided with the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.
I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to: (Please include name and contact information.) ****This release of information will remain in effect until terminated by me in writing****

Name:_____ Name:_____

Relationship:_____ Relationship:_____

Phone:_____ Phone:_____

Email:_____ Email:_____

I authorize Dr. Doyle to discuss my protected health information with the following family members or healthcare providers that care for me. I authorize the release of my medical health records from/to other healthcare providers that are caring for me.

I understand that I may revoke this authorization at any time, which will then apply to any future disclosures of my protested health information. I have been given the opportunity to review the Notice of Privacy Practices available in the office.

Dated:_____ Patient's Name: _____ Signature: _____

Signature of Parent or Guardian (if minor): _____