Welcome to Colorado Springs Chiropractic
Patient and Contact Information & History

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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:

Home Phone: Cell Phone: Work Phone:

Occupation: Marital Status: ☐ Single ☐ Married ☐ Divorced

E-mail Address:

Emergency Contact Name: Phone:

Insurance Information:

Plan Name: Subscriber Name:

Subscriber ID #: Group #: Spouse Name:

How did you hear about our office?

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

Doctors Notes:

NEUROLOGICAL & METABOLIC CASE HISTORY

What is the main problem/symptom that you are having?

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 did this begin? How did this begin?

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

No

What makes your condition worse?

What makes your condition better?

Do you experience Numbness or Tingling?

No

If yes, where? Does it radiate down the arm(s), leg(s), back or other?

SYMPTOM INTENSITY: Please choose the number describing the intensity of symptoms.

0/None

When you are awake, how often are you feeling these symptoms? (0-100%)

Does this affect you at night?

When do you experience this throughout the day (AM/PM/All Day)?

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

Is this progressively getting worse?

Is your condition: ☐ Constant ☐ Comes & Goes

Have you had any treatment for this problem in the past? If yes, when/by whom?

No

How did the previous method(s) work for you?

Are there any conditions that run in your family?

If yes, what condition(s) and what family member?

When was your last: Physical Blood/lab work X-ray MRI

Have you been treated for your current condition before? If yes, when/by whom?

No

Surgical History: Please list the type and reason of surgery, and year performed (e.g. left breast for cancer in 2004)

REVIEW OF SYSTEMS

Changes in or loss of smell? ☐ Normal ☐ Loss ☐ Increased ☐ Decreased

Monovision Correction?

Visual changes or loss of vision?

Difficulty with visual focus or activity?

Double vision? If yes, in which direction?

☐ Dry eyes? ☐ Dry Mouth? ☐ Excessive tearing or saliva?

Weakness or numbness of the face?

☐ Difficulty hearing ☐ Ringing in the ears?

Maintaining balance with or without head movements?

Light headedness/dizziness when rising from a lying or seated position?

Sensations of spinning? If yes, which direction?

Difficulty swallowing foods?

☐ Poor digestion? ☐ Constipation? ☐ Diarrhea? ☐ Abnormal bowel movements?

☐ Bladder control issues?

Changes in sexual function or ability?

Increasing food sensitivities? ☐ Gluten? ☐ Dairy? ☐ Other?

Excessive bloating?

Difficulty shrugging or raising your arms or shoulders?

Slurring your words or your tongue feeling thick?

Sweaty hands or feet?

Cold hands or feet?

Noticeable sweating difference on the right or the left?

Please check any of the following conditions or complaints that you have or are experiencing

☐ AD/HD	☐ Adrenal Disorder	☐ Anxiety	☐ Arthritis	☐ Asthma
☐ Atypical Facial Pain	☐ Arm or Leg Pain	☐ Autoimmune Condition	☐ Balance Problems	☐ Bleeding Disorder
☐ Blood Sugar Issues	☐ Blurred Vision	☐ Buzzing in Ear(s)	☐ Carpal Tunnel	☐ Cancer
☐ Celiac Disease	☐ Chest Pains	☐ Chronic Fatigue	☐ Colitis/Diverticulitis	☐ Compression Fractures
☐ Concussion	☐ Connective Tissue	☐ COPD	☐ Depression	☐ Diabetes: ☐ 1 ☐ 2
☐ Digestive Issues	☐ Dizziness	☐ Double Vision	☐ Dyslexia	☐ Ear Infections
☐ Fibromyalgia	☐ Food Sensitivity	☐ Fusions (Spinal)	☐ Gout	☐ Gall Bladder Issue
☐ Headache	☐ Heart Disease	☐ Hepatitis: ☐ A ☐ B ☐ C	☐ Herpes	☐ High Blood Pressure
☐ Hip Replacement	☐ HIV/AIDS	☐ Immune Deficiency	☐ Insomnia	☐ Joint Pain
☐ Kidney Disease	☐ Liver Disease	☐ Low Back Pain	☐ Migraine	☐ Multiple Sclerosis
☐ Neck Pain	☐ Osteoporosis/Pena	☐ Regional Pain Synd. (CRPS)	☐ Rotator Cuff Issues	☐ Shoulder Pain
☐ Stroke/TIA	☐ STI/STD	☐ Tremors	☐ Trigeminal Neuralgia	☐ TMJ
☐ Thyroid Issues	☐ Tuberculosis	☐ Tingling ☐ Burning ☐ Numbness in Hands or Feet		☐ Vertigo

PATIENT FINANCIAL RESPONSIBILITY PATIENT RECORD OF DISCLOSURES/HIPAA ACKNOWLEDGEMENT

Thank you for choosing Colorado Springs Chiropractic. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our Patient Financial Responsibility Policies and HIPPA Acknowledgment.

INSURANCE: The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you; however, it is the patient's responsibility to know the details of their insurance in addition to any lapses in insurance coverage. If you do not inform us of special requirements required by your plan, and we provide medically necessary services that are not covered by your plan, we may bill you directly for those charges.

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

CANCELLATION/NO SHOW OF APPOINTMENTS: When an appointment is not kept, it creates an unused appointment slot that could have been used for another patient. It is very important that you call to cancel your appointment. **If for any reason you need to cancel or reschedule an appointment, please notify our office within 24 hours to avoid a fee of $30.00 for cancellation or $45 for no shows.**

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

E-MAIL/TEXT MESSAGING: Patients in our office may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience and to provide general health reminders/information. If at anytime you provide an e-mail or text address at which you may be contacted, you are consent to receiving appointment reminders and other healthcare information/communications at that email/text address from the Practice. *This practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).*

☐ I consent to receive text messages from the practice at my cell phone or e-mail as stated below I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information.

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.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided 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 wish to be contacted in the following manner(check all that apply):

- Home Phone:
- Cell Phone:
- E-Mail:

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

Name: Name:

Relationship: Relationship:

Phone: Phone:

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

Signature of Patient/Guardian: Date:

Colorado Springs Chiropractic

Informed Consent Document

To the patient: 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 manipulative 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.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

--Spinal manipulative therapy --Palpation --Vital Signs
--Range of motion testing --Orthopedic testing --Neurological testing
--Postural analysis --EMS/TENS/Galvanic --Imaging and Lab studies as indicated
--hot/cold therapy --Stretching --massage therapy --exercise rehabilitation
--Microcurrent --low level laser therapy --SSEP --Functional medicine/supplements --Other_____

The material risks inherent in chiropractic care

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and physiotherapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strains, ligament sprains, cervical myelopathy, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke (CVA). Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. Cauda Equina Syndrome has been reported in rare cases which requires immediate medical care.

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 check 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 not 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 and nature of other treatment options

Other treatment options for your condition may include:

-Self-administered, over-the-counter (OTC) analgesics, ice, head or rest.
-Medical care and prescription drugs such as anti-inflammatories, muscle relaxants and pain killers.
-Hospitalization/Surgery

If you choose to use on 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 and dangers 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: **PATIENTS NAME:** **SIGNATURE:**

SIGNATURE OF PARENT OR GUARDIAN (if minor):

DATED: **DOCTOR'S NAME:** **Dr.DavidDoyle** **SIGNATURE:**