Rock Chiropractic

Where miracles can happen

Parker, Co 303-840-2092

Patient Application Pg1

Confidential Health Information

Date:

1 PATIENT CONTACT

Last Name:	First Name:	Middle Initial:
Preferred to be Called:	Occupation:	
Address:	Who can we thank for referring you?	
City: / State:	Zip:	
Home Phone:	Cell Phone:	
Work Phone:	E-mail:	
	Insurance:	

2 PATIENT PERSONAL

Age:	Date of Birth:	Social Security #:	Gender: M / F

Marital Status: Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced ☐

Name of Spouse:	Names and Ages of Children:

3 EMERGENCY CONTACT

Name:	Home Phone:
Relationship:	Cell Phone:

4 GENERAL HEALTH

Have you ever had Chiropractic Care? ☐ Yes ☐ No		Frequency of past adjustments?	How long ago?
The goal of todays appointment?		Do you have any allergies? (specify)	
How often do you drink alcoholic beverages?		Any drug related allergies? (specify)	
Do you exercise? ☐ Yes ☐ No	Type?	Frequency?	Do you Smoke? ☐ Yes ☐ No How Much?

Have you ever suffered from or been diagnosed as having any of the following, write P to the side for past conditions:

Yes	No		Yes	No		Yes	No	
☐	☐	*Head Aches/Problems	☐	☐	Ear Infections	☐	☐	Ruptures
☐	☐	Neck problems	☐	☐	Frequent colds	☐	☐	Coughing Blood
☐	☐	Shoulder Problems	☐	☐	Asthma	☐	☐	Digestive Problems
☐	☐	Arm Problems	☐	☐	Menstrual Cramps	☐	☐	Alcoholism
☐	☐	Numb - Arms / Hands	☐	☐	Tiredness / Fatigue	☐	☐	Drug Addiction
☐	☐	Pain b/w Shoulders	☐	☐	*Broken or Fractured Bones	☐	☐	HIV Positive
☐	☐	Low Back Problems	☐	☐	Circulatory Problems	☐	☐	Gall Bladder
☐	☐	Leg Problems	☐	☐	*Rheumatoid Arthritis	☐	☐	Depression
☐	☐	Numb - Legs / Feet	☐	☐	Seizures/Convulsions	☐	☐	Tumors
☐	☐	Painful/Stiff Joints	☐	☐	A Congenital Disease	☐	☐	Epilespy
☐	☐	Sinus Problems	☐	☐	Excessive Bleeding	☐	☐	Pacemaker
☐	☐	Sore Muscles	☐	☐	High/Low Blood Pressure	☐	☐	Strokes
☐	☐	Dizziness	☐	☐	*Diabetes	☐	☐	*Cancer
☐	☐	Fainting	☐	☐	*Osteoarthritis	☐	☐	Ulcers

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Patient Application Pg 2

5 Medication List

Please use other page if necessary

Names of all Medications	Names of Vitamins	Non-Rx / Rx	Date Started/Stopped	Who Prescribed Dr. / Self
		☐ ☐		☐ ☐
		☐ ☐		☐ ☐
		☐ ☐		☐ ☐
		☐ ☐		☐ ☐
		☐ ☐		☐ ☐

Miscellaneous Notes:

6 Systems Review

Please check the box C if you currently have this symtom, P if you have had it in the past and NA if neither apply. Please do not leave any blanks.

C	P	NA		C	P	NA	
☐	☐	☐	High / Low Blood Pressure	☐	☐	☐	Diarrhea
☐	☐	☐	Dizziness/Fainting	☐	☐	☐	Nausea
☐	☐	☐	Insomnia	☐	☐	☐	Female Problems
☐	☐	☐	Low Resistance: Chronic Colds/Flu	☐	☐	☐	Prostate Problems
☐	☐	☐	Tension	☐	☐	☐	Hands/Feet Cold
☐	☐	☐	Confusion	☐	☐	☐	Hand Tremors
☐	☐	☐	Tiredness / Fatigue	☐	☐	☐	Loss of Memory
☐	☐	☐	Ulcers	☐	☐	☐	Nervousness
☐	☐	☐	Eye/Vision Problems	☐	☐	☐	Sweaty Palms
☐	☐	☐	Difficulty Breathing	☐	☐	☐	Speech Difficulty
☐	☐	☐	Heart problems	☐	☐	☐	Anxiety
☐	☐	☐	Loss of Bladder Control	☐	☐	☐	Depression
☐	☐	☐	Constipation				

Doctors Use Only

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s).

Dr. Name/Facility	Problem	Type of Treatment Received	Dates of Care

Doctors Notes Only:

7 Main Complaint

What is your primary complaint?

On the scale below, please rate the severity of your **primary** complaint (At it's worst):

0. No pain	1. Slight Discomfort	2. Slight pain	3.	4. Moderate Pain	5.	6.	7. Severe Pain	8.	9. **Pain keeps me bed ridden**	10. **Pain that causes thoughts of suicide**

On the scale below please rate the percentage of time you experience your **primary** complaint:

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	**100%**

How long have you suffered with this problem?

What have you done to try to correct this problem?

Subluxations can cause irritation to different fibers within nerves. What do you suffer from: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Cramping ☐ Shooting ☐ Stabbing ☐ Tingling ☐ Throbbing ☐ Numbness

When severe enough subluxations will cause radiating ☐ Pain ☐ Tingling ☐ Numbness down to the ☐ Arms ☐ Hands ☐ Legs or ☐ Feet

CA / Dr. Notes Only:

When do you notice the pain most? ☐ Worse AM ☐ Worse PM ☐ Worse w/Activity ☐ Constant / Daily

Have your ever had this in the past ☐ ☐ | How long does the pain last? Minutes Hours

How many times in the past have you had this?

What makes it feel better? | What makes it feel worse?

Have you missed work because of your primary complaint? ☐ Yes ☐ No | Dates missed?

Before you began to suffer with this problem, was there an earlier accident, injury or condition that may or may not have been directly related to this problem? (i.e. falls, sports injuries, repetitive motion) Yes ☐ No ☐

If yes, please explain.

Are you pregnant? | Number of pregnancies? | Miscarriages? | Date of last menstrual cycle?

8 Other Health Complaints

Please list other health complaints on the following lines:

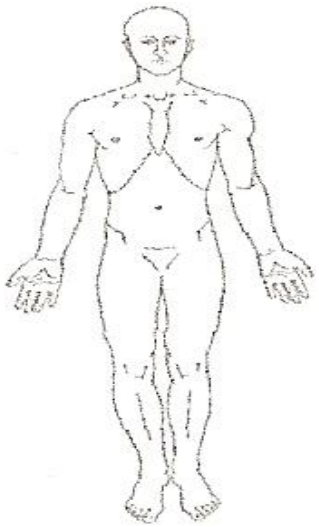
Complaint:	2	3	4
When did it 1st occur?			
What makes it better?			
What makes it worse?			
What type of pain?			
Where does it radiate?			
Location of complaint?			
Timing/Frequency of complaint?			

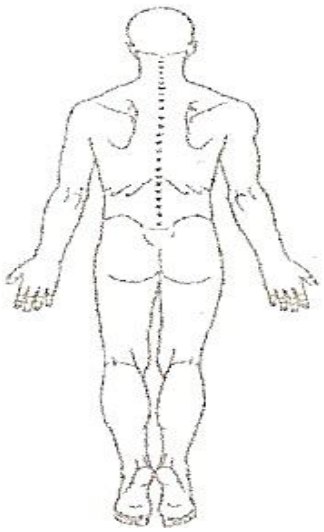
Doctor's Notes Only: _____

8 Continued

Please mark ALL the areas of all of your complaints on the diagrams below using the following letters:

A= Aching
B = Burning
C= Cramping
D= Dull
N= Numbness
S= Sharp
T= Tingling
SH= Shooting
ST= Stabbing
TH= Throbbing





9 Daily Activities

Please indicate how the following activities are effected by your complaints:

Carrying Groceries	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Sit to Stand	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Climbing Stairs	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Pet Care	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Driving	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Extended Computer Use	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Household Chores	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Lifting Children	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Reading	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Concentrating	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Bathing	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Dressing	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Shaving	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Sexual Activities	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Sleep	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Static Sitting	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Static Standing	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Yard work / Snow Shoveling	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Walking	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Reaching	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Kneeling	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Bending	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Recreational Activities				
*Please list your own				
1_____	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
2_____	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
3_____	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
4_____	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐

On a scale of 1 to 10, ten being the highest, rate your commitment to making lifestyle changes to get rid of this problem:

Please specify your concerns that could interfere with your commitment (time, transportation, etc):

10 Injuries

From birth traumas and chronic poor posture to traumas and injuries throughout our lives, subluxations can occur, damaging our nervous systems.

Please list any **auto collisions** that you were involved in, either as the driver or passenger. Begin with the most recent.

Front, Back or Side Collision	Type of Treatment Received	Speed of Collision	Date of Collision
1			
2			
3			

Please list any **job injuries and/or repetitive movement** you have experienced. Begin with the most recent.

Type of Job Injury	Type of Treatment Received	Missed Worked Days	Date of Job Injury
1			
2			
3			

Please list any **sports injuries/traumas** you have now or have had in the past that may have caused subluxations.

Type of Injury	Type of Treatment Received	Type of Sport Playing	Date of Sports Injury
1			
2			
3			

Please list any **other injuries** caused during recreational activities, falls or impacts. Begin with the most recent.

Type of Injury	Type of Treatment Received	Activity Participating In	Date of Injury
1			
2			
3			

PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness:

- ☐ None
- ☐ ADD
- ☐ Depression
- ☐ Measles
- ☐ Unusual Childhood Illness
- ☐ Allergies/Hayfever
- ☐ Diabetes
- ☐ Mumps
- ☐ Asthma
- ☐ Fetal Drug Exposure
- ☐ Rash
- ☐ Atopic Dermatitis
- ☐ Food Allergies
- ☐ Seizure Disorder
- ☐ Cerebral Palsy
- ☐ Headaches
- ☐ Sickle Cell Anemia
- ☐ Chicken Pox
- ☐ Hepatitis
- ☐ Spina Bifida

Adult Illness:

- ☐ None
- ☐ Anemia
- ☐ CVA
- ☐ Hepatitis
- ☐ Seizures
- ☐ Arthritis
- ☐ Depression
- ☐ Hypertension
- ☐ Similar Symptoms
- ☐ Asthma
- ☐ Diabetes (Insulin Dep.)
- ☐ Kidney Disease
- ☐ STD's
- ☐ Cancer
- ☐ Diabetes (NIDDM-Noninsulin)
- ☐ Liver Disease
- ☐ Suicide Attempts
- ☐ Chicken Pox
- ☐ Eye Problems
- ☐ Lung Disease
- ☐ Thyroid Problems
- ☐ CRPS (RSD)
- ☐ Heart Disease
- ☐ Psychiatric Problem

Surgeries:

- ☐ None
- ☐ Angioplasty
- ☐ Cosmetic
- ☐ Joint Replacement
- ☐ Gallbladder
- ☐ Appendectomy
- ☐ D&C
- ☐ Laminactomy
- ☐ Caesarean Section
- ☐ Hemorrhoidectomy
- ☐ Mastectomy
- ☐ Cardiac Catheterization
- ☐ Hernia Repair
- ☐ Pacemaker Insertion
- ☐ Carpal Tunnel Repair
- ☐ Hysterectomy
- ☐ Spinal Fusion
- ☐ Coronary Bypass
- ☐ Joint Reconstruction
- ☐ Tonsillectomy
- ☐ Other: _____

Ob/Gyn – Describe: _____

- ☐ None

Injuries – Describe: _____

- ☐ None

Immunizations:

- ☐ None
- ☐ Flu
- ☐ PPD
- ☐ TD
- ☐ Small Pox
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Varivax
- ☐ MMR
- ☐ Pneumonia
- ☐ Others

Non-Drug Allergies-Describe: _____

- ☐ None

FAMILY HISTORY

	Alive	Deceased	Condition (of Health or reason for Death)
General Family	___	___	_____
Father	___	___	_____
Mother	___	___	_____
Paternal Grandfather	___	___	_____
Paternal Grandmother	___	___	_____
Maternal Grandfather	___	___	_____
Maternal Grandmother	___	___	_____
Son(s)	___	___	_____
Daughter(s)	___	___	_____

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have been notified and given the opportunity to read a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

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Terms and Conditions
Communication

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency chiropractic services, or any service performed without prior financial arrangements, must be paid for with cash, check or credit card at the time services are performed.

The patient is ultimately responsible for payment in full for their account, not the insurance company. We do, however, submit chiropractic insurance claims as a courtesy to our patients. We can only make estimates regarding you insurance company's reimbursement to our office based on the information provided by you as well as the insurance company. This office uses our usual and customary fees. The undersigned hereby consents to pay any and all balance on their account for chiropractic services rendered as agreed upon in the individual's care plan recommendations.

If it is necessary for our office to turn your account over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs (30%) and/or attorney fees, in addition to the balance owed. Any account turned over to a collection agency forfeits any past special fees or discounts.

I grant my permission to Dr. Miller or staff members of Rock Chiropractic to telephone me at home or at my work to discuss matters related to this form.

I have read the above terms and conditions of treatment. I understand and agree to the content of this form.

_____
Patient Signature

_____
Date

Patient communication

I would like to receive communication from Rock Chiropractic via:

_____ Telephone

_____Text Messaging

_____ Email

_____ All of the Above

I give Rock Chiropractic permission to send messages to me via email and/or text messaging as a means of communication as indicated by my selection above.

_____ _____
Patient Signature Date

Rock Chiropractic

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Informed Consent

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternative.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Printed Name 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 Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:
(Please complete if you are a female of any age)

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.
Date of last menstrual cycle: ____/____/____

_____ _____

Signature Date