

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 <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/>			
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type?	Frequency? Do you Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> 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	
<input type="checkbox"/>	<input type="checkbox"/>	*Head Aches/Problems	<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Ruptures
<input type="checkbox"/>	<input type="checkbox"/>	Neck problems	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	Coughing Blood
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems
<input type="checkbox"/>	<input type="checkbox"/>	Arm Problems	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism
<input type="checkbox"/>	<input type="checkbox"/>	Numb - Arms / Hands	<input type="checkbox"/>	<input type="checkbox"/>	Tiredness / Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction
<input type="checkbox"/>	<input type="checkbox"/>	Pain b/w Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	*Broken or Fractured Bones	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder
<input type="checkbox"/>	<input type="checkbox"/>	Leg Problems	<input type="checkbox"/>	<input type="checkbox"/>	*Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Numb - Legs / Feet	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Tumors
<input type="checkbox"/>	<input type="checkbox"/>	Painful/Stiff Joints	<input type="checkbox"/>	<input type="checkbox"/>	A Congenital Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Sore Muscles	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Strokes
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	*Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	*Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	*Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers

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
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>
Miscellaneous Notes:				

6 Systems Review		Please check the box C if you currently have this symptom, 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	Doctors Use Only					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		High / Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Female Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Low Resistance: Chronic Colds/Flu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hands/Feet Cold
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hand Tremors
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Tiredness / Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Memory
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Eye/Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweaty Palms
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech Difficulty
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Constipation				

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

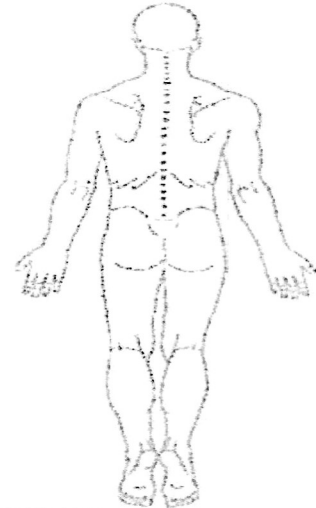
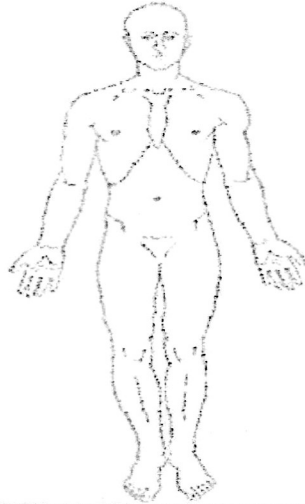
Dr. Name/Facility	Problem	Type of Treatment Received	Dates of Care

Doctors Notes Only:

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

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
- Laminectomy
- Caesarean Section
- Hemorrhoidectomy
- Mastectomy
- Cardiac Catheterization
- Carpal Tunnel Repair
- Hysterectomy
- Spinal Fusion
- Coronary Bypass
- Joint Reconstruction
- Tonsillectomy
- Other: _____

Ob/Gyn – Describe: _____

- None

Injuries – Describe: _____

- None

Immunizations:

- | | | |
|------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> None | <input type="checkbox"/> MMR | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Flu | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Shingles # ___ |
| <input type="checkbox"/> PPD | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> COVID # ___ |
| <input type="checkbox"/> TD | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> RSV |
| <input type="checkbox"/> Small Pox | <input type="checkbox"/> Varivax | <input type="checkbox"/> 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

Rock Chiropractic

Where miracles can happen

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 your 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

Where miracles can happen

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