APPLICATION FOR CARE AT CARDINAL CHIROPRACTIC

cardinal chiropractic

13648 Orchard Parkway, Ste 800, Westminster, CO 80023 (303) 953-7888 info@cardinalfamilychiro.com

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ **Birth Date:** ____-____-____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

For future appointment confirmation do you prefer: ☐ Text ☐ Email ☐ Phone Call **Cell Phone Provider:** _____
(Our software requires this information to make calls or send texts/emails.)

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No **Insurance Provider:** _____

Do you make your own financial decisions? ☐ **Yes** ☐ **No**

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Number of children and Ages: _____

Whom may we thank for referring you to this office → _____?

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____

Secondarily: _____ Third: _____ Fourth: _____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

- **Primary** or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 ☐ Constant ☐ Intermittent
- **Second** complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 ☐ Constant ☐ Intermittent
- **Third** complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 ☐ Constant ☐ Intermittent
- **Fourth** complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 ☐ Constant ☐ Intermittent

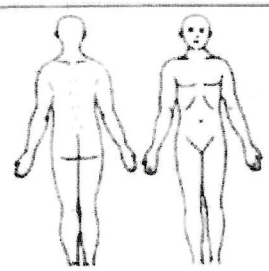
When did the problem(s) begin? _____ **When is the problem at its worst?** ☐ **AM** ☐ **PM** ☐ **mid-day** ☐ **late PM**

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes; **If yes,** when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B** = Burning **D** = Dull **A** = Aching **N** = Numbness **S** = Sharp/ Stabbing **T**= Tingling

What relieves your symptoms? _____

What makes them feel worse? _____

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐ **No** ☐ **Yes** **If Yes** how many times? _____

When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____, and **who** provided it: _____ **How long ago?** _____ What were the results: ☐ Favorable ☐ Unfavorable

Please explain. _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

Mark any of the following if you have ever been diagnosed or currently have any of the listed conditions:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions: _____

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PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

1. **Smoking**: ❑cigars ❑ pipe ❑ cigarettes → How often do you smoke? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. **Alcoholic Beverage**: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. **Recreational Drug use**: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. **Hobbies -Recreational Activities- Exercise Regime:** ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

How does your present problem affect the following? _____

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
   If **yes whom**: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)
   Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. **Any** other hereditary conditions the doctor should be aware of. ❑ No ❑ Yes: _____

Please mark any and all of the problems you currently have or have had in the last 6 months:

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus Problems	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

I hereby authorize payment to be made directly to Cardinal Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Cardinal Chiropractic for any and all services I receive at this office. **JDD,DC 5/2011**

_____
Patient Name (Print)

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

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Patient's Name: _____ HR#: _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carrying Items	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ 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
Weight Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bathing/Showering	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Shaving	☐ 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	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Cardio Exercise	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Eating	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Stretching	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Steps	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Other: _____	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

Patient signature: _____ Today's Date: ___/___/___

JDD,DC 5/2011

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

	Headache				Neck				Low Back		
No pain	0	1	(2)	3	4	(5)	6	7	(8)	9	10	**worst possible pain**

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1 – What is your pain RIGHT NOW?

No pain	0	1	2	3	4	5	6	7	8	9	10	**worst possible pain**

2 – What is your TYPICAL or AVERAGE pain?

No pain	0	1	2	3	4	5	6	7	8	9	10	**worst possible pain**

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain	0	1	2	3	4	5	6	7	8	9	10	**worst possible pain**

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain	0	1	2	3	4	5	6	7	8	9	10	**worst possible pain**

OTHER COMMENTS:

_____

_____

_____
Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Cardinal Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Cardinal Chiropractic at (303) 953-7888. If we are unavailable, you may make an appointment see come in within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I can receive a copy of Cardinal Chiropractic's Patient Privacy Notice at any time. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name _____ DOB _____ HR# _____

Patient signature _____ Date _____

Witness _____ Date _____

CARDINAL CHIROPRACTIC

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Medical Information Release Form (HIPAA) & Informed Consent

Name: _____ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse: _____

[ ] Child(ren): _____

[ ] Other: _____

*This **Release of Information** will remain in effect until terminated by me in writing.*

REGARDING: CHIROPRACTIC ADJUSTMENTS, ASSESSMENTS, RE-EVALUATIONS:

I am aware that after reviewing this document, chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Cardinal Chiropractic have been laid out to my satisfaction. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____

Patient or Authorized person's Signature Date

REGARDING: X-RAYS AND IMAGING STUDIES

By my signature below I am acknowledging that I have reviewed this information and understand that x-ray exposure may cause birth defects and other hazardous effects such as growth and developmental delays of an unborn child (if female is pregnant). I have also conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____

Patient Name (Print) Date of Birth

_____ ____/____/____

Patient or Authorized person's Signature Date

FEMALES ONLY → *Please read carefully and let a team member know if you have further questions*

☐ The first day of my last menstrual cycle was on ____ ____ ____ (Date)

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am NOT pregnant

OFFICE USE ONLY:

C AP _____ T AP _____ L AP _____

Witness Initials

Extracorporeal Shockwave Therapy Patient Consent Form

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Suitability for ESWT Therapy

By answering the following questions, you will assist us to decide if you are suitable for ESWT.

- Do you have a cardiac pacemaker?* Yes / No
- Do you have any active Cancers / Tumors?* Yes / No
- Are you pregnant or suspect you may be pregnant?* Yes / No
- Have you been injected with Cortison in the last 21 days? Yes / No
- Do you have any known blood disorders? Yes / No
- Are you currently taking any blood-thinning medication? Yes / No
- Do you have a history of Tinnitus or ringing in the ears? Yes / No
- Are you 18 years of age or under? Yes / No

RISK OF THIS PROCEDURE

A) Pain and soreness. This is temporary and usually resolves after a few days.
B) The FDA has labeled this a "Non-Significant Risk" therapy for cleared Indications.

CONSENT FOR PROCEDURE

I, _____, consent to ESWT for addressing the area of:

_____.

I have been informed about Extracorporeal Shockwave Therapy (ESWT) and understand its purpose, benefits, and potential outcomes as explained by my physician/staff. I have had the chance to ask questions, and no guarantees have been made regarding pain relief or improved function.

Signed _____ Date: _____