CARDINAL FAMILY CHIROPRACTIC NEW PATIENT INTAKE

Name:_____ Today's Date:_____

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

Home Telephone: ( )_____ Work: ( )_____ Cell:( )_____

Email Address: _____ Sex:

Social Security Number: _____ Birth Date: _____ Age:_____

Occupation: _____

Employer Name and Address:_____

Status: Spouse's Name: _____

Do you have one of the following? HSA FLEX UHC CIGNA UHC BCBS AETNA

Have you seen a Chiropractor before? ◯ Yes ◯ No If yes, when?_____

Whom may we thank for referring you to our office? _____

YOUR HEALTH HISTORY

Please ☑ check all symptoms you have ever had, even if they do not seem related to your current problems.

- ☐ Headaches
- ☐ Pins and Needles in arms
- ☐ Dizziness
- ☐ Numbness in fingers
- ☐ Fatigue
- ☐ Sleeping problems
- ☐ Cold Sweats
- ☐ Mood Swings
- ☐ Pins and Needles in legs
- ☐ Loss of smell
- ☐ Buzzing in ears
- ☐ Numbness in toes
- ☐ Depression
- ☐ Neck Stiff
- ☐ Constipation
- ☐ Lights bother eyes
- ☐ Menstrual Pain
- ☐ Fainting
- ☐ Back Pain
- ☐ Ringing in ears
- ☐ Loss of taste
- ☐ Irritability
- ☐ Cold hands
- ☐ Fever
- ☐ Problem urinating
- ☐ Menstrual irregularity
- ☐ Neck Pain
- ☐ Loss of Balance
- ☐ Nervousness
- ☐ Stomach upset
- ☐ Tension
- ☐ Cold feet
- ☐ Hot flashes
- ☐ Heartburn
- ☐ Ulcer

Main Complaint:_____

List any medications you are taking: _____

Have you been in a car accident recently? ◯ Yes ◯ No If so, when? _____

This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of its availability: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Office Use only ID#: _____

Functional Rating Index

Regarding your MAIN COMPLAINT

In order to properly assess your condition, we must understand how much your main complaint problems have affected your ability to manage everyday activities.

For each item below, please select the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain no restrictions	Mild pain no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on shorts trips	Severe pain on short trips

5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25 % of usual work	Cannot work

6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Name_____

PRINTED

_____ _____

Signature **Date**

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 _____ **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

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1 – What is your pain RIGHT NOW?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

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

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

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

No pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

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

14694 Orchard Parkway, Ste 200, Westminster, CO. 80023 303-953-7888 ca@cardinalfamilychiro.com

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: _____
( ) Children : _____
( ) 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 risks are more 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 hearby 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.

_____ Date: ____/____/____

Patient or Authorized Person's Signature

REGARDING: X-RAYS AND IMAGING STUDIES:

By my signature below I am ackowledging 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 have therefore, do hearby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ DOB: ____/____/____

Patient Name (Print)

_____ Date: ____/____/____

Patient or Authorized Person's Signature

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*

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 Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to permitted to disclose information about you to a third party without 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 an 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 purpose.
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 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 record 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 and 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 Policy 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 (Print) DOB HR#

_____ _____
Patient's Signature Date

_____ _____
Witness Date

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: _____