Thrive Chiropractic and Wellness

1190 Bridge Street | Brighton, CO 80601
Phone (303) 659-4220 | Fax (303) 659-1832

ABOUT THE PATIENT

Name _____

Address _____

City _____ State _____ Zip _____

email (will not be shared) _____

Phone: (H) _____ (W) _____ (C) _____

DOB _____ Age _____ Male ☐ Female ☐

☐Single ☐Married ☐Divorced ☐Widowed ☐Seperated

Social Security # (required) _____

Employer _____

Occupation _____ ☐Full ☐Part time

Payment Method: ☐Cash ☐Check ☐Credit Card

ABOUT YOUR SPOUSE

Name _____

DOB _____ SS# _____

Employer _____

Occupation _____

Health Status: ☐Excellent ☐Good ☐Fair ☐Poor

CHIROPRACTIC EXPERIENCE

Who referred you to this office/how did you hear about us?

If applicable, approximate date of last chiropractic visit?

Has any adult in your family seen a Chiropractor?

Has any child in your family seen a Chiropractor?

REASON FOR THE VISIT

Describe your symptoms (prioritize by severity) _____

When did your symptoms start? _____

How did your symptoms begin? _____

How often do you experience your symptoms?

- ☐Constantly (76-100% of the day)
- ☐Frequently (51-75% of the day)
- ☐Occasionally (26-50% of the day)
- ☐Intermittently (0-25% of the day)

How are your symptoms changing?

- ☐Getting Better
- ☐Not Changing
- ☐Getting Worse

Using a 0-10 Pain Scale (0=No pain, 10=Most intense pain imaginable)

- Rate your current level of pain _____
- Rate your average pain level _____
- Rate the worst your pain gets _____
- Rate the lowest your pain gets _____

Has this condition occurred before? ☐Yes ☐No

Have you seen other doctor's for this condition? ☐Yes ☐No

Doctor's names and specialties _____

Types of treatment _____

Results _____

MEDICAL HISTORY

Broken Bones? _____

Surgeries? _____

_____

_____

Hospitalizations? _____

Motor Vehicle Accidents? _____

Been struck unconscious? _____

What medications are you taking and for what conditions? (If you have a list with you, please let us know and we will make a copy)

_____

_____

What vitamins, minerals, or herbs do you currently take? _____

_____

_____

Do you currently or have you had: (Please Mark all that apply)

	Current	Past
Infection	☐	☐
Unexplained Weight Loss	☐	☐
Unusual Fatigue	☐	☐
Dizziness/Double Vision	☐	☐
Poor Balance	☐	☐
Vomitted Blood	☐	☐
Bloody/Black stools	☐	☐
Change in Bowel/Bladder function	☐	☐
Fevers	☐	☐
Night Sweats	☐	☐
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Shortness of breath	☐	☐
Chronic cough	☐	☐
Stroke	☐	☐
Heart disease or murmur	☐	☐
Headaches	☐	☐
Muscle weakness or paralysis	☐	☐
Memory Loss	☐	☐
Direct head trauma	☐	☐
Osteoporosis	☐	☐
Cancer	☐	☐
Pain with breathing	☐	☐
Abdominal pain	☐	☐
Use of corticosteroids	☐	☐
Use of anticoagulants	☐	☐
numbness to groin (saddle anesthesis)	☐	☐
Incontinence	☐	☐

Family Members: present and past health conditions

(Example: Cancer, Stroke, Diabetes, Heart Disease, Arthritis, etc.) ____

_____

_____

_____

_____

_____

_____

_____

_____

Habits	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐

Hobbies/Interests _____

_____

_____

Job Satisfaction: ☐Unsatisfied ☐Satisfied ☐Very Satisfied Number of hours worked per week? ____ On the road? ____

In general how would you rate your health? ☐ Excellent ☐ Average ☐ Poor

Do you feel depressed or have trouble falling asleep, poor appetite, lack of interest in normally enjoyable activities, relationship problems:

☐ No ☐ Yes If yes please explain: _____

_____

_____

ABOUT YOUR CONDITION

I am here for wellness. ☐N/A

Do you experience pain every day? ☐NO ☐YES

Do your symptoms interfere with daily life? ☐NO ☐YES

Does the pain interfere with your sleep? ☐NO ☐YES

Do changes in the weather affect your symptoms? ☐NO ☐YES

Do your symptoms cause you to lose your temper? ☐NO ☐YES

Do you wear orthotics or a lift? ☐NO ☐YES

Are your symptoms worse during certain times of the day? ☐NO ☐YES

If yes, indicate time of day. ☐Morning ☐Noon ☐Night

What activities aggravate your symptoms? _____

Is there anything that you can no longer do because of the pain? If yes please explain?

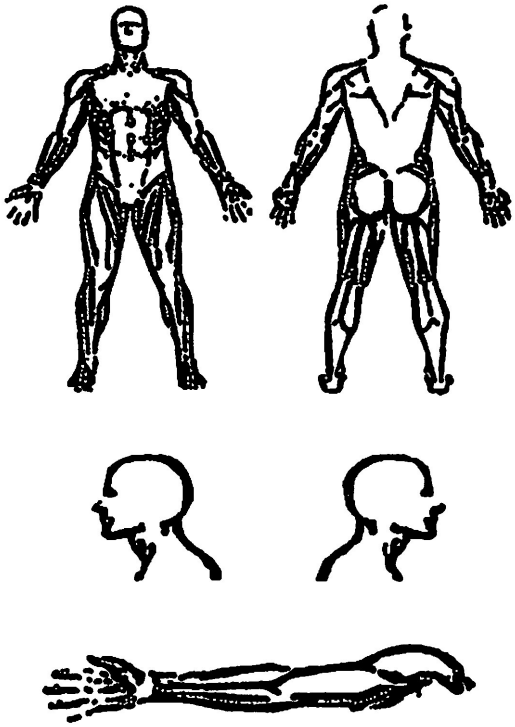
☐NO ☐YES_____

What have you done to alleviate your pain?_____

_____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A = ACHE B = BURNING N = NUMBNESS P = PINS AND NEEDLES S = STABBING O = OTHER



GOALS FOR MY CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and others for correction of whatever is malfuncitioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ I am only concerned about relief of a particular symptom.

☐ I am only concerned about relief of a particular symptom, and preventing its return.

☐ I want optimum health and well being on every level available to me.

☐ I want the Doctor to select the type of care appropriate for my condition.

ABOUT YOUR INSURANCE

Name of the primary/guarantor of the insurance policy? _____ D.O.B: _____

Your relationship to the guarantor [ ] Self [ ] Spouse [ ] Child [ ] Other

Guarantor's SS# _____ Guarantor's Employer: _____

Do you know your ins. policy's chiropractic benefits? If so, what were you told? _____

_____

If you have phoned your insurance company prior to your appointment:

Do you need a referral to be seen? [ ] Yes [ ] No

Financial Awareness and Consent: I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my major medical insurance benefits, including Medicare, private insurance, and other health plans to Thrive Chiropractic and Wellness. Any overpayment will be promptly refunded. I also authorize Thrive Chiropractic and Wellness to release any protected health information required to secure payment.

HIPAA Privacy Practices: The information within this chart is confidential. I understand that all requests for release of my records must be in writing. Protected health information will be released with written authorization, with minimum disclosure necessary as related to your care. Please see Notice of Privacy Practices for more detailed information. I understand I have a responsibility to communicate honestly with Dr. Kronemeyer or Dr. Roberts, and to notify him of any changes in my health status. I understand that a copy of my HIPAA rights is available to me upon request.

Informed Consent for Chiropractic Care: 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 alternatives.

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 vertebra 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 methods 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.

All health care procedures carry some risk. Risks associated with chiropractic are may include, but are not limited to, muscle or ligament injuries, nerve injuries, vascular injuries and fractures. Alternatives to chiropractic care may include medications, surgery, and other alternative treatments.

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 alternative 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.

* _____ * _____ * _____/_____/_____

(Print 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 information and hereby grant permission for my child to receive chiropractic care.

Statement of non-pregnancy for x-ray purposes:

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

Date of last menstrual cycle _____/_____/_____ _____ _____/_____/_____

(Signature) (Date)