



## WELCOME TO OUR OFFICE

We realize that this is your first visit to our office, and our past experience has shown us that new patients have many unanswered questions on their minds. Our staff will attempt to do everything possible to make you feel at ease, and to answer any questions that you may have.

To ensure your first visit with us is a pleasant one, here are the procedures you can expect during this visit.

1. **CONSULTATION:** Your doctor will talk to you, review your health history, and determine if yours is a chiropractic case. You will have time to discuss your health concerns with him.
2. **VIDEO:** To acquaint you with our office and explain how we help our patients regain their health, most patients see a short 8-minute video.
3. **EXAMINATION:** Standard physical, orthopedic, neurological, and chiropractic tests will be performed to determine the cause(s) of your problem.
4. **X-RAY:** Necessary views may be taken to visualize the location of any spinal problem, reveal any pathology, and make your chiropractic care more precise. Before proper care can be rendered, your doctor will study your examination findings. On your follow-up visit the doctor will review with you the findings, and give his specific care recommendations.
5. **FUTURE VISITS:** Your first visit is complete. Plan to spend about 30 minutes on your next visit to receive the doctor's report of findings and a chiropractic adjustment. Details regarding treatment, expectations, prognosis, health coverage, financial issues, etc. will be discussed in detail before your case is accepted for treatment.

### **Business Arrangement Policy**

We are committed to providing you with the best possible care. If you have health insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. Many times the expenses incurred by an individual for health care are paid by insurance companies. Recognizing this, it is our policy to accept assignment for health care rendered to our patients under the following circumstances:

1. Personal or group health insurance: (partial credit) It is the office policy to ask you to pay the portion of the bill that your insurance company does not pay.
2. Auto accident/insurance coverage: Partial to complete credit with chiropractic insurance coverage.
3. Work injury/compensation coverage: With the employer authorization partial to complete credit.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a service that we perform for our patients, all charges are your responsibility from the date the services are rendered. If there is no health insurance coverage which reimburses you for our services, arrangements will be made with you that will allow you to receive the needed care and take care of expenses on a daily, weekly, or monthly basis. We hope this serves as an introduction that explains and answers some of your questions. We sincerely believe that the best doctor/patient relationship exists when there is complete understanding of treatment and financial responsibilities between the doctor and the patient.

### Patient Questionnaire

Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ Age \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Your E-Mail \_\_\_\_\_  
 Fax Number (To Which Your Confidential Medical Information Can Be Sent) \_\_\_\_\_  
 Present Occupation \_\_\_\_\_ Previous Occupation? \_\_\_\_\_  
 Name of Spouse \_\_\_\_\_ (Or) Significant Other \_\_\_\_\_  
 Name and Address of Your Primary Care Physician \_\_\_\_\_  
 \_\_\_\_\_ Phone# \_\_\_\_\_

We At Vail Chiropractic Think It Important For Your Health Care Team To Communicate And Work Together. Would You Like Our Office To Send An Update To Your Medical Doctor? \_\_\_Yes \_\_\_No  
 Who Can We Thank For Referring You To Our Office: \_\_\_\_\_

Please List Your Current Hobbies: \_\_\_\_\_

Does Your Current Problem Hold You Back From Your Hobbies? \_\_\_Yes \_\_\_No  
 Do You Work Full-Time? \_\_\_Yes \_\_\_No  
 Does Your Present Problem Involve a Lawsuit or Motor Vehicle Accident? \_\_\_Yes \_\_\_No  
 Does Your Problem Involve a Worker's Compensation Claim? \_\_\_Yes \_\_\_No

If Yes, Give Name of Worker's Compensation Carrier: \_\_\_\_\_

Do Any of Your Family Members Have Problems Possibly Related Their Spine? \_\_\_Yes \_\_\_No  
 Have Any of Your Family Members Or Friends Had Similar Problems?

Explain: \_\_\_\_\_

Have You or Any of Your Family Members Seen or Received Treatment from a Chiropractor? \_\_\_\_\_

\_\_\_\_\_

What Is Your Spine Problem at This Time? \_\_\_\_\_

How Did Your Problem Start? \_\_\_\_\_

How Long Has This Problem Been Present? \_\_\_\_\_

Have You Ever Had a Similar Condition? \_\_\_\_\_

Have You Been Treated For This Problem Before? \_\_\_\_\_

Has Your problem been getting? Worse \_\_\_ Not Changed \_\_\_ Better \_\_\_ Other: \_\_\_\_\_

Have You Ever Been Check For VERTEBRAL SUBLUXATIONS? \_\_\_\_\_ Yes \_\_\_ No

If Injury, Was This a Work-Related Injury? \_\_\_ Yes \_\_\_ No If Yes State Date and Circumstances: \_\_\_\_\_

Have You Had Other Significant Spine Injuries in the Past?

Explain: \_\_\_\_\_

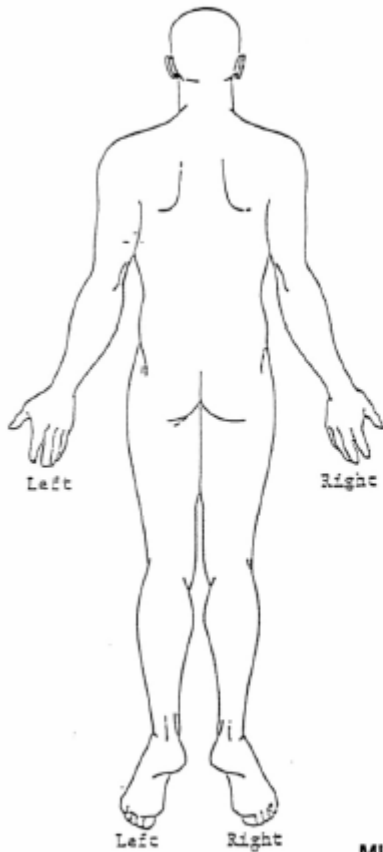
Mark the areas on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

ACHING: = = = =

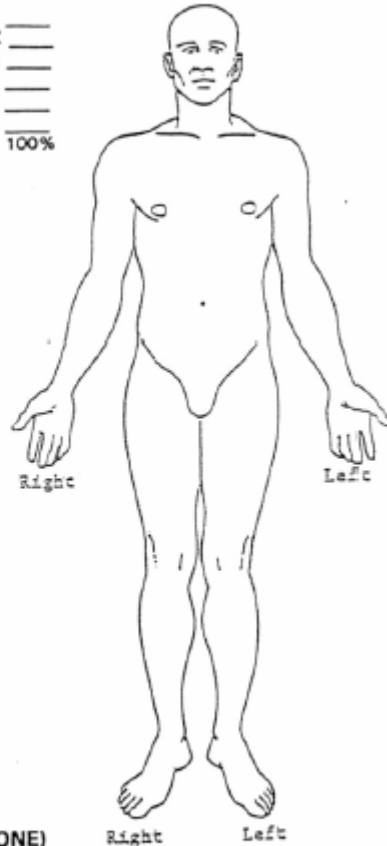
PINS & NEEDLES: 0000

BURNING: XXXX

SHARP & STABBING: ///



- 1. % PAIN IN LOW BACK \_\_\_\_\_
- 2. % PAIN IN RT. BUTTOCK \_\_\_\_\_
- 3. % PAIN IN LT. BUTTOCK \_\_\_\_\_
- 4. % PAIN IN RIGHT LEG \_\_\_\_\_
- 5. % PAIN IN LEFT LEG \_\_\_\_\_
- 6. % PAIN ELSEWHERE \_\_\_\_\_
- TO TOTAL: 100%



PAIN SCALE (CIRCLE ONE)  
MINIMAL 1 2 3 4 5 6 7 8 9 10 MAX

Choose no more than five that describe your pain. Please (X). Most important (XX).

- |                    |                     |                   |                    |
|--------------------|---------------------|-------------------|--------------------|
| 1. Steady [ ]      | 5. Intermittent [ ] | 9. Electrical [ ] | 13. Throbbing [ ]  |
| 2. Tiring [ ]      | 6. Punishing [ ]    | 10. Killing [ ]   | 14. Miserable [ ]  |
| 3. Crawling [ ]    | 7. Boring [ ]       | 11. Gnawing [ ]   | 15. Heavy [ ]      |
| 4. Suffocating [ ] | 8. Cruel [ ]        | 12. Annoying [ ]  | 16. Unbearable [ ] |

What time of the day does your pain get worse? Morning\_\_ Afternoon\_\_ Evening\_\_ At Night\_\_

What Makes Your Pain Worse? (Check All That Apply)
\_\_\_Lifting \_\_\_Bending \_\_\_Twisting
\_\_\_Sitting \_\_\_Standing \_\_\_Walking
\_\_\_Running \_\_\_Lying Down \_\_\_Position Change
\_\_\_Sleeping \_\_\_Coughing \_\_\_Sneezing \_\_\_Straining

What Makes Your Pain Better? (Check All That Apply)
\_\_\_Lying Down \_\_\_Sitting \_\_\_Standing
\_\_\_Pain Meds \_\_\_Anti-Inflammatories \_\_\_Walking

What Have You Done for Your Current Problem? ( Mark (Y): If It Helped, Mark (N); If it Did Not Help)
\_\_\_ Chiropractic Care \_\_\_Spinal Adjustment \_\_\_Physical Therapy
\_\_\_Spinal Rehab Exercises \_\_\_ Stretch/Exercise \_\_\_General Practitioner
\_\_\_Ice/Heat \_\_\_Bath/Shower \_\_\_Pain Reliever

Which of These Diagnostic Studies Have You Had For Your Current Problem?
\_\_\_MRI \_\_\_CT Scan \_\_\_Plain X-Rays \_\_\_Thermography \_\_\_sEMG

List All Present Medications and Supplements Below (Please Attach List if Space is Inadequate):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PRESENT SYSTEM REVIEW: (Check All Items Which Apply to You)

\_\_\_Excessive Stress \_\_\_Heart Problems \_\_\_Cancer
\_\_\_Bladder Problems \_\_\_Irregular Heart Rate \_\_\_Painful Joints
\_\_\_Bowel Problems \_\_\_Frequent Chest Pain \_\_\_Seizures or Blackouts
\_\_\_Stomach Problems \_\_\_Frequent Shortness of Breath \_\_\_Severe Headaches
\_\_\_Frequent Infections \_\_\_Bleeding or Bruising Tendency \_\_\_Significant Weight Gain or Weight Loss
\_\_\_Changes in Vision, Taste, Smell, and Hearing
\_\_\_Numbness/Tingling \_\_\_Arm/Leg Pain \_\_\_Weakness

Anything Else Not Listed? \_\_\_\_\_

PAST MEDICAL HISTORY REVIEW (Check Items Which Have Been Issues for You)

\_\_\_Arthritis \_\_\_Heart Disease \_\_\_Neck Problems
\_\_\_Cancer \_\_\_Hepatitis \_\_\_Osteoporosis
\_\_\_Depression \_\_\_High Blood Pressure \_\_\_Seizures
\_\_\_Diabetes \_\_\_High Cholesterol \_\_\_Suicide

PATIENT HOSPITAL/SURGICAL HISTORY (List Below All Surgeries and Hospitalizations)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LIST ANY MAJOR ACCIDENTS, ILLNESSES, INJURIES, TRAUMAS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SOCIAL HISTORY

Married? \_\_\_Yes \_\_\_No Children \_\_\_Yes \_\_\_No If Yes Ages \_\_\_\_\_  
Cigarette Smoker? \_\_\_Yes \_\_\_No If Yes Give Amount per Day \_\_\_\_\_ # Years \_\_\_\_\_  
List Any Other Nicotine Products That You Use \_\_\_\_\_  
Are You Aware That Smokers Have a 3-4x Higher Incidence of Disc Degeneration Than Non-Smokers? \_\_\_Yes \_\_\_No  
Alcohol Consumption? \_\_\_Yes \_\_\_No Amount? Week \_\_\_\_\_  
Do You Exercise Now? \_\_\_Yes \_\_\_No Daily? \_\_\_Yes \_\_\_No  
Type of Exercise \_\_\_\_\_  
No, What Exercise Have You Done in the Past? \_\_\_\_\_  
Have You Had A Chemical Dependency or Drug Addiction Problem? \_\_\_Yes \_\_\_No  
Yes State the Number of Years You Have Been Drug Free \_\_\_\_\_

FAMILY HISTORY

(Check off those involving immediate family and add identification as to:

Mother= (M) Father= (F) Siblings= (S) Grandparents= (G)

- |                         |                                   |                     |
|-------------------------|-----------------------------------|---------------------|
| _____ Abnormal Bleeding | _____ Heart Disease               | _____ Stroke        |
| _____ Scoliosis         | _____ Hepatitis                   | _____ Neck Problems |
| _____ Cancer (Type)     | _____ High Blood Pressure         | _____ Osteoporosis  |
| _____ Depression        | _____ High Cholesterol            | _____ Seizures      |
| _____ Diabetes          | _____ Lung Problems               | _____ Rheumatoid    |
| _____ Back Problems     | _____ Muscle, Nerve, Bone disease | _____ Arthritis     |

**IF A WORKERS COMPENSATION CASE**

Date of Injury \_\_\_\_\_ Circumstance of Injury (Explain) \_\_\_\_\_  
\_\_\_\_\_  
Name of Work Comp Carrier \_\_\_\_\_  
Name of Your Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Adjuster's Name \_\_\_\_\_  
Adjuster's Address \_\_\_\_\_  
Adjuster's Phone \_\_\_\_\_ Adjuster's Fax \_\_\_\_\_  
Do You Have a Case Worker? \_\_\_Yes \_\_\_No or a QRC? \_\_\_Yes \_\_\_No  
If Yes Who? \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address of Caseworker or QRC \_\_\_\_\_

**IF A LAWSUIT**

Explain\_\_\_\_\_

Attorney Contact Information\_\_\_\_\_

Attorney Phone # \_\_\_\_\_

**IF A MOTOR VEHICLE ACCIDENT**

Explain\_\_\_\_\_

Give Date\_\_\_\_\_ Auto Carrier's Name\_\_\_\_\_

Claim#\_\_\_\_\_ Adjuster's Name\_\_\_\_\_

Adjuster Phone\_\_\_\_\_ Adjuster Fax\_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurer\_\_\_\_\_ Secondary Insurer\_\_\_\_\_

Insurer Address\_\_\_\_\_ Sec. Insurer Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_ City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Policy/ ID#\_\_\_\_\_ Policy/ ID#\_\_\_\_\_

Group#\_\_\_\_\_ Effective Date\_\_\_\_\_ Group#\_\_\_\_\_ Effective Date\_\_\_\_\_

Policy Holder\_\_\_\_\_ DOB\_\_\_\_\_ Policy Holder\_\_\_\_\_ DOB\_\_\_\_\_

Your Employer's Name\_\_\_\_\_ Phone\_\_\_\_\_ Fax\_\_\_\_\_

Is a Referral Required for You to be Seen in Our Clinic? \_\_\_Yes \_\_\_No

NOTE: If Your Insurance Requires a Referral, and if Such is Not Provided, You Will be Responsible for the Payment of All Charges. All Co-payments are Due at the Time of the Appointment.

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

### CONSENT TO TREATMENT OF MINOR CHILD

I authorize the licensed doctor and whomever he/she may designate as his/her assistants to administer chiropractic care as he/she so deems necessary to my (relationship):

\_\_\_\_\_ (name): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### FEMALE PATIENTS

This is to certify that to the best of my knowledge I am NOT pregnant and that X-rays may be ordered. Beginning date of your last menstrual period (date): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to chiropractic manipulations and other procedures including various modes of physical therapy, diagnostic x-ray and/or tests by Vail Chiropractic Clinic P.L.L.C. and their staff who now or in the future treat me while employed by this office. I have had an opportunity to discuss with the doctor named above and/or with other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to aggravation/exacerbation fractures, disc injuries, stroke, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any future conditions for which I seek treatment by this clinic and/or employed staff.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made

and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I Understand, and Confirm, That the Above Information is Accurate

\_\_\_\_\_  
Patient Signature Date