

BODYWORKS CHIROPRACTIC
403 S Baldwin Street, Woodland Park, CO 80863

Chiropractic Case History

Today's Date: ____/____/____

Name _____ What you prefer to be called _____ Sex M F
Address _____ City _____ State _____ Zip _____
Phone _____ Hm Wk Cell Alternate Phone _____ Hm Wk Cell
E-Mail _____ Birthdate ____/____/____ Age _____
Employer _____ Occupation _____ Marital Status: S M D W
Emergency Contact _____ Phone # _____ Alt. # _____
Have you ever seen a chiropractor? ☐ Yes ☐ No Month/Year of last visit ____/____ Referred by _____

1. Primary Reasons for Seeking Care: (Ex: Pain Relief, Gain Mobility/Flexibility, Sleep Better, Be able to do... again, etc.)

Primary Reason: _____ Secondary Reason: _____

2. Chief Complaint: _____ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Well Care ☐

When did this complaint begin? _____

Did your injury/condition occur during: ☐ Work ☐ Auto Accident ☐ Sports/Play ☐ Routine Activity ☐ Other _____

Describe initial cause of complaint? _____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Have you had this or a similar condition before? ☐ Yes ☐ No Explain _____

Are you presently under a doctor's care for this complaint? ☐ Yes ☐ No Clinic/Doctors name: _____

Please circle the quality of the complaint/pain: **dull aching sharp shooting burning throbbing deep nagging tingling/numbness**

Does this complaint/pain radiate or travel (shoot) to other areas of your body? ☐ Yes ☐ No Where? _____

Do you have any numbness or tingling in your body? ☐ Yes ☐ No Where? _____

What aggravates the complaint? _____

What makes the complaint better? _____

Is your complaint interfering with your ☐ Work ☐ Sleep ☐ Daily Routine If so, how? _____

Are you taking any of the following medications? ☐ Pain Killers ☐ Muscle Relaxers ☐ Blood Thinner ☐ Insulin

☐ Tranquilizers ☐ Nerve Pills ☐ Other: _____

Are there any other health concerns you would like to address? _____

3. Previous interventions: (treatments, medications, surgery, or other care you've sought **for your chief complaint**)

4. Past Health History:

Previous serious medical conditions (dates): _____

Previous accidents/injury/trauma (dates): _____

Have you ever broken any bones? Which? _____

Allergies: _____

Other Medications (not listed above): _____

Conditions you are taking medications for: _____

Surgeries (dates): _____

5. Family Health History:

Mother: ☐ Living ☐ Deceased Health Issues/Cause of death _____

Father: ☐ Living ☐ Deceased Health Issues/Cause of death _____

Siblings: ☐ Living ☐ Deceased Health Issues/Cause of death _____

6. Social and Occupational History:

Activities required at work/job description: _____

Recreational activities: _____

Sleep hrs/night _____ Exercise hrs/week _____ Types of exercise _____

Do you take vitamins or supplements? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No # packs/day _____ #years _____

Alcohol drinks/week _____ Caffeine cups/day _____ Are you wearing? ☐ Shoe Lifts ☐ Arch Supports

Circle the number that represents your avg. pain: (1 = discomfort, 10 = intense) 1 2 3 4 5 6 7 8 9 10

Using the pictures and symbols shown below, mark the location and type of pain you feel.

Symbols

Numbness = = =

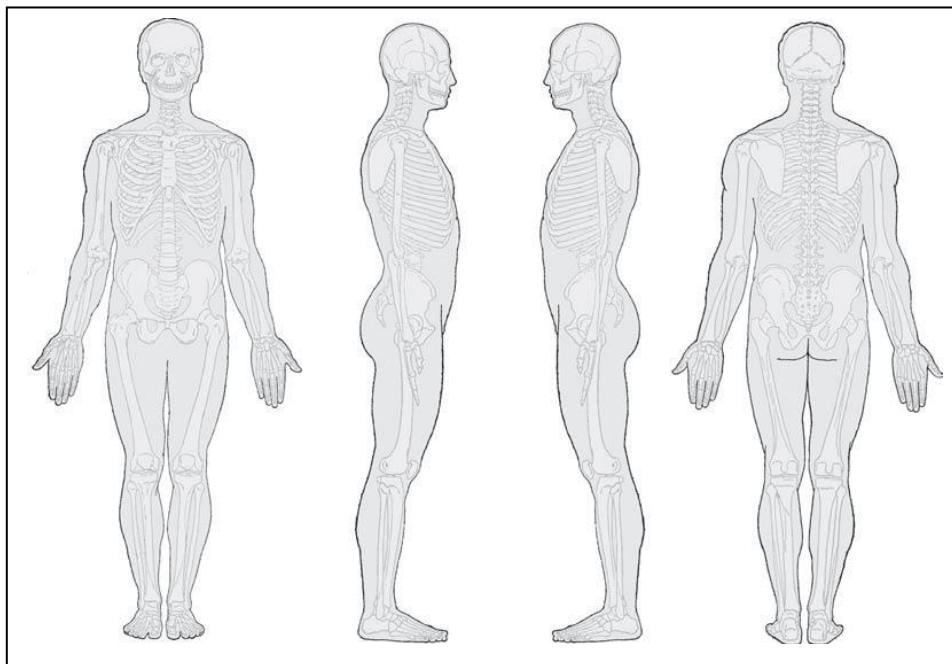
Dull Ache O O O

Burning X X X

Sharp/Stabbing / / /

Pins, Needles + + +

Other _____ ^ ^ ^



Please mark any of the following conditions or symptoms that you have now or have experienced:

- ☐ Severe/Freq. Headaches
- ☐ Neck Pain
- ☐ Sleeping Problems/Insomnia
- ☐ Low Back Pain
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Dizziness
- ☐ Pain between Shoulders
- ☐ Neck Stiffness
- ☐ Joint Swelling
- ☐ Fever
- ☐ Loss of Balance
- ☐ Ringing in Ears
- ☐ Jaw/TMJ Problems

- ☐ Pain in Hands or Arms
- ☐ Numbness in Hands or Arms
- ☐ Pain in Legs or Feet
- ☐ Numbness in Legs or Feet
- ☐ Fatigue
- ☐ Depression
- ☐ Lights Bother Eyes
- ☐ Loss of Memory
- ☐ Shoulder Pain
- ☐ Sinus
- ☐ Shortness of Breath
- ☐ Asthma/Emphysema
- ☐ Allergies
- ☐ Cold Hands or Feet
- ☐ HIV+/AIDS/ARC

- ☐ Chest Pains
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Painful Urination
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Constipation
- ☐ Stomach Upset
- ☐ Heartburn/Reflux
- ☐ Weight Loss
- ☐ Alcohol/Drug Abuse
- ☐ Psychiatric Problems
- ☐ Heart Surgery/Pacemaker
- ☐ Other, Please list below

FOR WOMEN ONLY:

- ___ Birth Control _____
- ___ Hormone Replacement
- ___ Cramps/Backaches
- ___ Excessive Flow
- ___ Hot Flashes
- ___ Irregular Cycle
- ___ Miscarriage
- ___ Painful Periods

- ___ Vaginal Discharge
- ___ Breast Pain
- ___ Menopause

Pregnant at this Time ____ Yes ____ No

Date of Last Menstrual Period _____

Pregnancies, Date of Deliveries, and Outcomes (list in the space provided below):

INSURANCE INFORMATION:

I understand that it is my financial responsibility to pay for services, at the time of service. If my insurance covers my treatment in part or in full, payment will be made directly to me upon submission of a claim for these services. I may choose to submit the claim myself, or I may request that the office submit the claim on my behalf.

Insurance Company _____ Ins. Phone # _____
Insured's Name _____ Insured's Date of Birth _____
Insured's ID. # _____ Insured's Group # _____
Spouse's Name _____ Spouse's Date of Birth _____
Spouse's Employer _____ Spouse's Phone (Work) _____
Spouse's Insurance Co. _____ Ins. Phone # _____
Spouse's I.D. # _____ Spouse's Group # _____
Present condition due to an injury? Yes ___ No ___ On the Job ___ Auto Accident ___ Other _____
Has the accident been reported? Yes ___ No ___ To Employer ___ Auto Carrier ___ Other _____

TERMS OF ACCEPTANCE:

I _____, do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Acupuncture including meridian therapy and dry needling techniques may be used. Physical therapy modalities including heat and electric stimulation may also be used.

CHIROPRACTIC

Although spinal manipulation is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows: Soreness may occur especially within the first few treatments similar to muscle soreness after exercise, temporary dizziness and nausea may be experienced but are relatively rare. Fractures and joint injury can occur and is usually associated with underlying conditions such as physical defects, deformities, and pathologies like weak bones from osteoporosis. When these conditions are detected this office will proceed with extra caution.

There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely rare.

Our only practice objective is to reduce and/or eliminate musculoskeletal conditions through manual therapy; however, we may use other procedures to help your body hold the adjustments. The beneficial effects of our procedures include decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of these procedures. If this office encounters non-chiropractic findings we will advise you and recommend the appropriate health care provider.

ACUPUNCTURE

There are some risks to treatment, including but not limited to some bruising of the skin and/or slight bleeding. The risk of infection is small when all needles are sterile. Needles are considered sterile when they are either disposable or are autoclaved according to applicable state legal requirement. We only use sterile disposable needles in this office. Benefits of acupuncture include improved immune functioning, decreased pain and inflammation, and improvement in symptoms, however, I appreciate there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of these procedures.

***I hereby certify that the statements and answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health. I have read and fully understand the above statements and I agree to allow this office to examine me for further evaluation.**

Signature _____ Date _____

HIPAA AUTHORIZATION

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Our *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this authorization. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time to obtain a current copy of the *Notice of Privacy Practices*.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

Patient Name: _____

Relationship to patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initial: _____ Reason: _____

Missed, Cancelled, and Late Appointment Policies:

If you cannot make your appointment, we require **at least 24 hour advanced notice**.

If you can't make your appointment, please let us know as soon as possible so we can offer it to someone else. Your consideration is appreciated because the sooner you call us the greater our chances of providing this time to someone else who needs it. Appointment times are very important to our patients as well as to us. When a patient fails to keep an appointment, this time goes unused. Even on short notice, another patient could have benefited from your appointment time. By implementing this policy, it is our goal to make as many appointments available to our patients as possible.

If a person fails to show for an appointment and/or does not provide at least 24 hour notice prior to cancelling then we will charge our full fee for the missed appointment. This fee must be paid in full before being scheduled for another visit. These charges will not be billed to your insurance provider. Your appointment time is allotted to you, so we will charge you for failure to cancel. A message left on our answering machine during or after office hours is fine, as long as it is left at least 24 hours prior to your scheduled visit. **Please cancel by Friday for a Monday appointment.**

This policy applies to the following missed appointments:

The individual was **previously informed** of this policy, and provided signature at the bottom of the form
The cancellation was **not** due to a **medical emergency**
The individual **failed to cancel** with at least **24 hour notice**

Late Appointment Arrivals

We ask for you to plan to arrive on time for your appointment. We operate on a schedule, and try our best to keep patients from having to wait. If you arrive **more than 10 minutes late** for your appointment, we may choose to reschedule your appointment and charge you for the missed appointment. If we choose to see you, your appointment time may be reduced and you will still be responsible for the full fee.

Multiple "no shows" may result in a discharge from this office.

We also recognize that life isn't perfect and that there are circumstances that are out of your control. We may choose to make an exception to the above policies at our discretion, when appropriate.

Preferred Method for Appt. Reminders:

(Circle One) Phone / Text _____ E-mail _____

Thank you for your cooperation in helping us to provide the best care possible!

Print Name _____

Signature: _____ **Date:** _____