WELCOME

PLEASE PRINT LEGIBLY

Name: _____Today's Date: _____

☐ **Male** ☐ **Female** Date of Birth ___/___/___ **Age** _____ Height ____'__ __ Weight_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Significant Other

Education: # of years completed: _____ ☐ Full time student ☐ Part time student ☐ Non-student

Home Address: _____

Street Address/P.O. Box City State Zip Code

Email address*: _____ ***used for Appointment Reminders & Office Announcements only**

How did you hear about us? _____

Occupation: _____ Employed:____ Full Time ____ Part Time

Work Status: Working without restrictions____ Working with restrictions____ Not working/Off since_____

Cell Phone #: _____Home phone #: _____Other:_____

Primary Care Physician: _____

Are we seeing you for an injury from:

__ Auto __ Sports Injury __ Work

__ Other __ No injury

EMERGENCY CONTACT INFORMATION:

Emergency Contact Person: _____

Phone #: _____ Relationship: _____

INSURANCE INFORMATION: __ I will be paying for the services myself **OR**

__ **Please bill:** __Auto Insurance __Worker's Compensation __United Healthcare __ UMR __ Medicare

General Consent Form: It is understood that options exist for treatment and that any/all treatments have risks and benefits. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts given, is in my best interest. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested by the doctor and that as a patient, I have a responsibility to ask any questions that I may have regarding treatment. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment. I understand that I have a responsibility to communicate honestly with the Doctors and to notify them of any changes to my health status. The information in my chart is confidential. I understand that all requests for release of my records must be in writing. By signing below, I consent to the treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Financial Awareness and Consent: Your insurance policy is a contract between the insurance company and you. Although we verify your coverage, specific details regarding your benefits may change. 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 Scott Chiropractic of Fort Collins P.C. I understand that all plans are different and I may have one or more of the following that I am responsible for: referral from PCP/ deductible/ co-pays/ percentage owed for each date of service.

*Payment for services is required *at the time* of service.

** If you have a deductible on your insurance plan, a minimum of $55.00 is due at the time of service for each visit. Remaining charges applied to your deductible will be billed to you after it is processed by your insurance company.

***'Payment at time of service' discount*:** I understand that I may pay for my treatment in full at the time of service and will receive any and all treatments for a $55 flat rate (subject to change). If I choose to bill any insurance company, all services will be itemized and will exceed $55. I also authorize *Scott Chiropractic of Fort Collins P.C to release any protected health information required to secure payment.

Release of Records: I authorize *Scott Chiropractic to release all health records necessary for my treatment and/or evaluation.

ASSIGNMENT: Patient assigns Scott Chiropractic Fort Collins P.C. any and all benefits and payments from the Patient's medical insurance company, Med-Pay insurer, workers' compensation insurer, and/or any other health benefit plan for services provided by Medical Providers related to the Incident.

Cancellation Policy: I understand that I will be responsible for an office visit and/or fee for failure to cancel or reschedule my appointment within 24 hours of my scheduled appointment.

Patient's Signature: _____ Date:_____

Responsible Party's Signature (if patient is minor): _____ Date:_____

What is your **major** complaint? _____

When did your condition develop? _____

How did your condition develop? _____

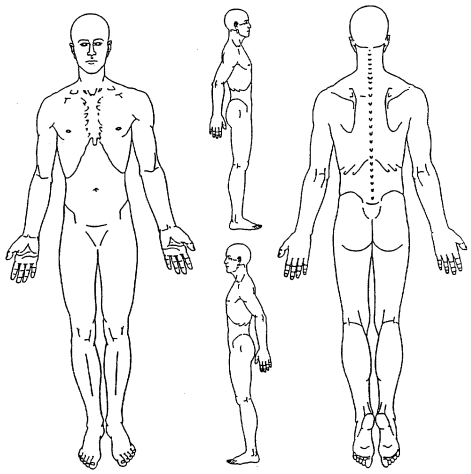
Has your condition been getting better, worse or staying the same? _____

What makes your condition better? _____ What makes it worse? _____

On a scale from **1-10** (10 being the worst pain you have ever felt), where is your pain level today? _____

Please mark on the diagram to explain and locate the areas of complaint.

A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER



Do you currently or in the past have: Please mark all that apply,

Please mark all that apply:	When	# episodes
☐ Back pain or stiffness	_____	_____
☐ Neck pain or stiffness	_____	_____
☐ Shoulder pain	_____	_____
☐ Hip pain	_____	_____
☐ Foot pain or trouble	_____	_____
☐ Swollen or painful joints	_____	_____
☐ Cold hands or feet	_____	_____
☐ **Numbness** or pain in the arms, hands, or fingers	_____	_____
☐ **Numbness** or pain in the legs, feet, or toes	_____	_____

TESTS: Please list the MOST recent date:

Chest X-ray _____ EKG _____ Other X-ray _____ MRI/CT Scans _____

HABITS:	YES	NO	If yes, please describe:
Smoking	☐	☐	Packs per day: 0 – ½ ☐ ½ - 1 ☐ 2 or more ☐ Duration _____
Alcohol Consumption	☐	☐	# Drinks per day _____ Drinks per week _____
Coffee or Tea Consumption	☐	☐	Cups per day _____
Other Drug Use (Street Drugs)	☐	☐	_____
Exercise	☐	☐	Daily ☐ Weekly ☐ Monthly ☐ Type _____

MEDICINES: Please list all currently used medicines. Include prescription and non-prescription drugs, vitamins, and herbs.

_____

_____

ALLERGIES: Please list all known allergies, especially to medicines. _____

_____

Treatment you are receiving or have received:

☐ Medical Care Who is your Primary Care Physician? _____

☐ Chiropractic Care If yes, when and with whom? _____

☐ Other: (Please specify)_____

FEMALES ONLY: Do you have: ☐ Menstrual problems ☐ Breast lumps or pain ☐ Tubal Infections ☐ Problems getting pregnant

Are you currently or possibly pregnant? _____

MALES ONLY: Do you have: ☐ Changes in urine stream ☐ Prostate trouble ☐ Lump in testicles

DOCTORS USE ONLY:

Left Eye: Right Eye: Corrected: Y / N BP: Pulse: Accom: L R Height: Weight:

HOSPITALIZATIONS, OPERATIONS, AUTO ACCIDENT or WORK INJURIES EVALUATIONS & TREATMENT/ YEAR
(Please be specific)

1. _____
2. _____
3. _____
4. _____
5. _____

Do you currently or have you had: Please mark all that apply.

	Current	Past
Sleep Problems	☐	☐
Disabled	☐	☐
Nervous tension	☐	☐
Irritability	☐	☐
Mood Swings / changes	☐	☐

Do you currently or have you had: Please mark all that apply.

	Current	Past
More frequent urination	☐	☐
Pain or blood with urination	☐	☐
Kidney or bladder infection	☐	☐
Kidney stones	☐	☐
Recurrent abdominal pain	☐	☐
Ulcers	☐	☐
Heartburn	☐	☐
Swallowing problems	☐	☐
Hernia	☐	☐
Hemorrhoids	☐	☐

Do you currently or have you had: Please mark all that apply.

	Current	Past
Arthritis or gout	☐	☐
Bursitis	☐	☐
Fractured bones	☐	☐
Seizures	☐	☐
Tremor	☐	☐
Passing out	☐	☐
Speech problems	☐	☐
Trouble concentrating	☐	☐
Diarrhea or constipation	☐	☐

FAMILY HISTORY:

Please note any family history of any of the below Conditions and include relationship of relative to you.

- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Headaches _____
- ☐ High Blood Pressure _____
- ☐ Arthritis _____
- ☐ Epilepsy _____
- ☐ Heart Disease _____
- ☐ Stroke _____
- ☐ Spine or Back Disorder _____
- ☐ Multiple Sclerosis _____
- ☐ Psychological Problems _____

Do you currently or have you had: Please mark all that apply:

	Current	Past
History of trauma	☐	☐
Infection	☐	☐
Unexplained weight loss	☐	☐
Unusual fatigue	☐	☐
Dizziness / Poor balance	☐	☐
Vomited blood	☐	☐
Bloody or black stools	☐	☐
Change in appetite	☐	☐
Fevers	☐	☐
Night Sweats	☐	☐
High blood pressure	☐	☐
Chest Pain	☐	☐
Shortness of breath	☐	☐
Chronic cough	☐	☐
Stroke	☐	☐
Heart disease or murmur	☐	☐
Loss of bowel or bladder control	☐	☐
Headaches	☐	☐
Muscle **weakness** or paralysis	☐	☐
Memory loss	☐	☐
Severe trauma	☐	☐
Direct head trauma	☐	☐
Lost consciousness	☐	☐
Poor coordination	☐	☐
Night pain	☐	☐
Difficulty Swallowing	☐	☐
Recent infection	☐	☐
History of osteoporosis	☐	☐
History of cancer	☐	☐
Difficulty breathing	☐	☐
Abdominal pain	☐	☐
Use of corticosteroids	☐	☐
Use of anticoagulants	☐	☐
Use of birth control pills	☐	☐
Numbness in groin (saddle anesthesia)	☐	☐
Loss of anal sphincter tone, fecal incontinence (bowel accidents)	☐	☐
Pain fails to improve with rest	☐	☐
Pain greater than 4 weeks	☐	☐
Prolonged use of corticosteroids	☐	☐
Intravenous drug use	☐	☐

Do you currently or have you had: Please mark all that apply.

	Current	Past
Asthma	☐	☐
Eczema	☐	☐
Hay Fever	☐	☐
Sinus Problems	☐	☐
Diabetes	☐	☐
High cholesterol or triglycerides	☐	☐
Thyroid trouble	☐	☐
Liver trouble	☐	☐
Anemia	☐	☐
Bleeding or bruising tendency	☐	☐

Any other serious illnesses not mentioned here: _____