C H I R O P R A C T I C | D E N V E R , C O

"BE TRUE TO YOUR BODY, AND YOUR BODY WILL BE TRUE TO YOU"

New Patient Information

First Name_____ Last Name_____Sex M F

Address_____City_____ State_____Zip_____

Phone (_____)_____ ☐ C ☐ H Email_____

Preferred Method of Contact: ☐ Email ☐ Phone listed above Date of Birth___/____/____ Age_____

Occupation_____Employer_____

Referred by_____

I am: ☐ Right Handed ☐ Left Handed ☐ Ambidextrous Marital Status: M S W D

Have you ever received Chiropractic Care? ☐ Yes ☐ No

Are you interested in? ☐Acute Symptom Care – pain relief

☐Injury Prevention Care - uses rehabilitation to help prevent flare-ups

☐Wellness Care – regular appointments to help promote optimum health and movement

Current Complaints

Describe major complaint (Problem #1).

_____

_____

_____

When did this first begin?_____

What percentage of the day do you feel the complaint? ☐ 25% ☐ 50% ☐75% ☐100%

Have you had MRI, CT scan, X-rays for this complaint? ☐No ☐Yes: When? Results?

_____

_____

Is your condition: ☐ Improving ☐ Getting worse ☐ The Same Does pain wake you from deep sleep? ☐ No ☐ Yes Are symptoms interfering with: ☐ Work/School ☐ Sleep ☐ Activities/Sports ☐ Home Life Have you seen any other healthcare providers (MD's, PT's, etc.) for this condition? ☐ No ☐ Yes Please describe:

_____

_____

_____

_____

Problem #2:

_____

_____

_____

_____

Problem #3

_____

_____

_____

Social History

How is most of your day spent? ☐ Standing ☐ Sitting ☐ Walking ☐ Lifting/Carrying

What sports/physical activities do you participate in? How often?

_____

_____

_____

Do you smoke? ☐ No ☐ Yes

Caffeine Servings? ☐ 4-6x/w ☐ 2-3x/w ☐ 1-2x/w ☐Seldom/Never

Eat "fast" food? ☐ Daily ☐ Weekly ☐ Seldom ☐ Never

Consume alcohol? ☐ Daily ☐ Weekly ☐ Seldom ☐ Never

Notes:_____

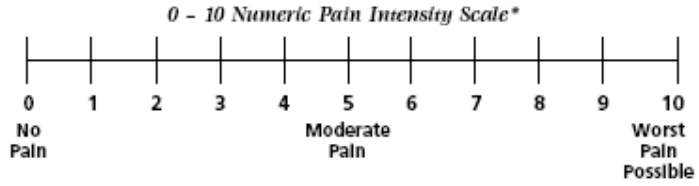
_____

_____

_____

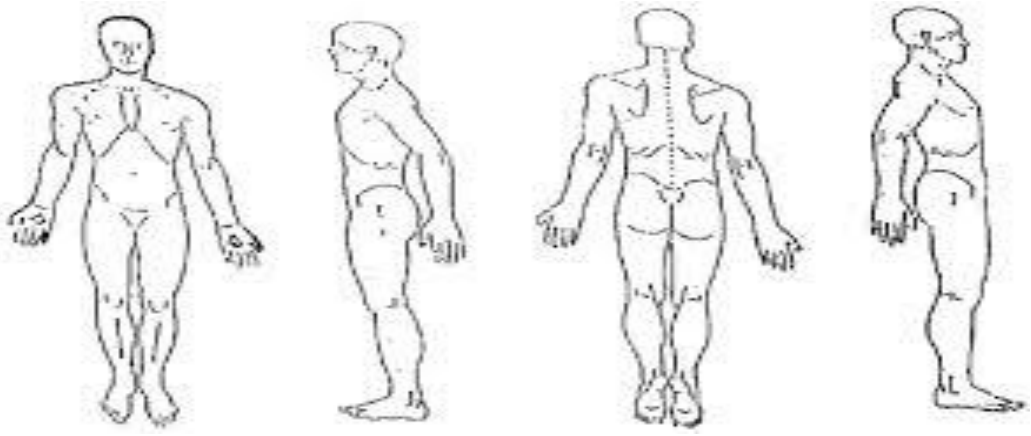
Please complete the following:

Circle the appropriate number below.



Mark the following letters on the person:

A - Ache	B - Burn	D - Dull	N – Numbness
P - Pins and Needles	S - Stabbing		
T - Throbbing	X – Scar	W- Weak	



Past Health History

A. Any surgeries, hospitalizations, recent illnesses?

B. Previous injuries or traumas?

C. Have you ever broken any bones? Which? When?

D. Any medications or herbs/vitamins?

E. Associated health problems of relatives:

Review of Systems

Check any of the conditions you have:

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mental illness
- ☐ Tremors
- ☐ Unexpected weight loss/gain

Skin
- ☐ Boils
- ☐ Bruise easily
- ☐ Hair/nail changes
- ☐ Hives/allergies
- ☐ Itching
- ☐ Varicose veins

EENT
- ☐ Blurry vision
- ☐ Colds
- ☐ Deafness
- ☐ Ear ache
- ☐ Eye pain
- ☐ Gum trouble
- ☐ Ringing of the ears
- ☐ Sinus infections
- ☐ Sore throat
- ☐ Tonsillitis
- ☐ Vision problems

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody or tarry stool
- ☐ Colitis/Crohn's
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Diverticulosis
- ☐ Bloated abdomen
- ☐ Excessive hunger
- ☐ Gallbladder trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Painful defecation
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Prostate trouble
- ☐ Stress incontinence
- ☐ Painful urination
- ☐ Urgency to urinate

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hardening of arteries
- ☐ Irregular pulse
- ☐ Pain over heart
- ☐ Palpitation
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Slow heart beat
- ☐ Swelling of ankles

Respiratory
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever
- ☐ Shortness of breath
- ☐ Spitting phlegm/blood
- ☐ Wheezing

Women Only
- ☐ Lumps in breast
- ☐ Menopause
- ☐ Vaginal discharge
- ☐ Irreg. menstrual flow

Pregnant? □ yes, □ no If yes, what month?

_____

Check any of the conditions you have or have had:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cold sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart burn
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ Influenza
- ☐ Measles
- ☐ Multiple sclerosis
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcer

Patient Informed Consent to Treatment

I do hereby give my consent to the performance of conservative noninvasive 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. Physical therapy and exercises may also be used. Physical examination is physical! It involves the doctor manually challenging your joints and testing your muscle strengths and it can sometimes lead to temporary soreness or worsening of your pain. I hereby request and consent to the performance of the above indicated procedures. I have had an opportunity to discuss with the doctors of chiropractic the nature and purpose of the procedures indicated above. I understand that results are not guaranteed.

I understand 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 fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to her, is in my best interest.

I have read the explanation above regarding chiropractic treatment. I have had the opportunity to have questions answered to my satisfaction. By signing below I agree to the above-named procedures. 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.

Patient Health Information and Privacy Policy

The policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPPA) is available here: https://www.cms.gov/hipaageninfo/.

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following, appointment reminders that will be used by the Practice: a) you are giving permission to be placed on the email list for the office for but not limited to office information and office newsletters; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me. 8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

Patient Signature _____ Date _____/_____/_____

Financial Policy

Payment for the examination and treatment is required at the time of service. For your convenience, we accept cash, checks, Mastercard, and AMEX, Discover, and Visa. If you have chiropractic insurance, we are interested in you receiving the maximum benefits. As an added service to you, our office will provide you with a superbill for you to submit to your insurance company. However, please be advised:

1. Your insurance policy is a legal contract between you, your employer, and the insurance company.

2. Dr. Joseph Vear is not a member of any HMO, PPO, or other provider networks. Any coverage you may have for services at this office will be deemed "out of network coverage" by your insurance company.

3. You remain ultimately responsible for all charges incurred in this office.

Cancellation Policy

At True Form Chiropractic, we respect your time and pride ourselves on being on time. There is a charge of 50% of the appointment cost for missed appointments if the visit is not cancelled 24 hours prior to the appointment time. We do this by scheduling responsibly. In order for us to maintain this high quality of service, we require patients give us a 24-hour warning if they will be unable to make their appointment. If a patient does not give us this warning period, which will allow us to fill their appointment; it is our policy to charge for the missed appointment. I understand the above statement and will give a 24-hour notice if I will be unable to make my appointment or I will pay for the missed appointment.

Patient Signature _____ Date_____/_____/_____

Consent for Treatment of a Minor

The information I have given this office is complete and true to the best of my knowledge. I authorize Dr. Joseph Vear to administer such procedures and treatment to _____(minor's name) as necessary. I certify that I have authority and responsibility to authorize treatment for this child.

Further, as the parent of legal guardian, I am responsible for the health decisions of my minor child and agree to cover the financial responsibilities for him/her.

Print Patient name_____ Date _____/_____/_____

Print Parent name_____

Parent Signature _____