970-332-4336
327 Main Street

DUNN CHIROPRACTIC

New Patient Intake Paper Work

Today's Date: ____/____/____

Patient Information:

First Name:_____(Preferred Name:_____) MI:_____ Last Name:_____

Billing Address:_____

City:_____ State:_____ Zip Code:_____

Primary Phone: (_____)_____-_____ [ ] Home [ ] Work [ ] Cell

Secondary Phone:(____)_____-_____ [ ] Home [ ] Work [ ] Cell

Cell Phone Carrier (for reminder text):_____

Emergency Contact Name & Phone:_____ (____)_____-_____

Primary E-mail Address:_____

(Note: We will only use your address for the purpose of electronic communications, such as events and promotions. We will never sell or share your information with outside companies)

Birthday: _____/_____/_____

Gender: [ ] Male [ ] Female Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Legally Separated

Associations:

Employment\Student Status (check one): [ ] Employed Full-Time [ ] Student Full-Time [ ] Not Employed [ ] Employed Part-Time [ ] Student Part-Time [ ] Retired

Employer Information:

Name:_____

Address:_____

City:_____ State:_____Zip Code:_____

Occupation\Job Description:_____

Whom may we thank for referring you to our office?_____

[ ] Family\Friends [ ] Other Patients [ ] Your Primary Care Doctor [ ] Insurance Provider Directory [ ] Other

1. Are your present problems due to? (if none of the below apply, skip to question2)
   - [ ] An Automobile Accident
   - [ ] A personal injury that requires a lawyer
   - [ ] *Or, do none of the above apply*
   - [ ] An injury/accident that occurred at your job injury/accident (Workman's Comp)
   - [ ] Any injury/accident that will **not** be turned into your normal health insurance

2. Who is your current Medical Doctor? Name:_____Phone: (_____)_____-_____

3. When did your current complaints begin (approximately)?

   _____

4. Describe how your complaints began:_____

5. Having you had an ongoing history of a similar condition? [ ] Yes [ ] No

   If yes, when did the problem initially present itself?_____

6. Have you ever been hospitalized? [ ] Yes [ ] No
If Yes, please list dates and reasons below:

Date(s)	*Hospital Name & Location*	*Reason*

7. List any broken bones or fractures you have suffered:_____

8. Do you suffer from any other medical conditions we should be aware of? [ ] Yes [ ] No
If yes, what_____?

9. Are you presently taking any prescription medication? [ ] Yes [ ] No
If yes, please list them below, or **if you have a list please present it to us to copy:**

Medication	*Dose*	*Frequency Taken*	*Start Date*

10. Do you currently take any nutritional supplements?
If yes, please list them below:

Supplement	*Quantity*	*Frequency Taken*

11. Have you or anyone in your family ever had any of the following problems?

	Self	Mother	Father	Sister	Brother	Other (Specify)
Diabetes	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]_____
Heart	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]_____
Kidney	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]_____
Cancer	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]_____
Back Pain	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]_____
Stroke	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]_____

12. Do you take Over-The –Counter Pain Relievers? [ ] Yes [ ] No If Yes, what?_____

How Often?_____Pills per [ ] day [ ] week [ ] month

13. **FOR FEMALES ONLY**:
Do you currently menstruate? [ ] Yes [ ] No
Have you reached menopause? [ ] Yes [ ] No
If yes, what was the starting date of your last menstrual period? _____/_____/_____
Are you pregnant at this time? [ ] Yes [ ] No
If yes, what is your projected due date? _____/_____/_____
What was the date of your last pap smear?_____/_____/_____
What was the date of your last mammogram?____/____/_____
Do you perform monthly self-breast exams?_____/_____/_____
Do you feel your cycle is regular? [ ] Yes [ ] No

14. Please Consult the chart below and fill it in as completely as possible.
Mark the boxes as "P" for previously applies to me, or "C" for currently applies to me. Leave the box blank if it does not apply to you.

General Symptoms
__ Headache
__ Fever
__ Chills
__ Night Sweats
__ Fainting
__ Dizziness
__ Convulsions
__ Loss of Sleep
__ Fatigue
__ Nervousness
__ Loss of Weight
__ Numbness or pain
__ in arms\legs\hands
__ Allergy
__ Wheezing
__ Neuralgia

Muscles & Joints
__ Weakness
__ Twitching
__ Stiff Neck
__ Backache
__ Swollen Joints
__ Tremors
__ Foot Trouble
__ Painful Tail Bone
__ Pain Between Shoulders
__ Spinal Curvature

Genito-Urinary
__ Frequent Urination
__ Painful Urination
__ Blood in Urine
__ Kidney Infection
__ Bed Wetting
__ Inability to Control Urine
__ Prostate Trouble

Gastro-Intestinal
__ Poor Appetite
__ Poor Digestion
__ Belching or Gas
__ Nausea
__ Vomiting
__ Vomiting Blood
__ Pain Over Stomach
__ Constipation
__ Diarrhea
__ Colon Trouble
__ Hemorrhoids (Piles)
__ Fluid Retention
__ Liver Trouble
__ Gout
__ Jaundice
__ Gall Bladder Trouble
__ Irritable Bowels

Cardiovascular
__ Rapid Heart
__ Slow Heart
__ High Blood Pressure
__ Low Blood Pressure
__ Pain Over Heart
__ Heart Trouble
__ Swelling Ankles
__ Poor Circulation
__ Varicose Veins
__ Strokes
__ Palpitations

__ **Respiratory**
__ Chronic Cough
__ Spitting Blood
__ Spitting Phlegm
__ Chest Pain
__ Difficult Breathing

Eye\Ear\Nose\Throat
__ Poor Vision
__ Crossed Eyes
__ Pain in Eyes
__ Deafness
__ Earache
__ Ear Discharges
__ Nasal Obstructions
__ Nose Bleeds
__ Sore Throats
__ Hoarseness
__ Hay Fever
__ Asthma
__ Frequent Colds
__ Enlarged Thyroid
__ Tonsillitis
__ Sinus Trouble

Skin or Allergies
__ Skin Eruptions
__ Itching
__ Bruising Easily
__ Dryness
__ Boils
__ Hives
__ Eczema

Conditions
__ Alcoholism
__ Epilepsy
__ Anemia
__ Goiter
__ Pleurisy
__ Appendicitis
__ Heart Disease
__ Pneumonia
__ Arthritis
__ HIV Positive
__ Polio
__ Cancer
__ Influenza
__ Rheumatic Fever
__ Chicken Pox
__ Low Back Pain
__ Scoliosis
__ Diabetes
__ Eczema
__ Mental Disorder
__ Whiplash

PLEASE FEEL FREE TO USE THE REMAINING SPACE ON THIS PAGE TO FURTHER ELABORATE ON ANY OF THE QUESTIONS WE HAVE ASKED.

Informed Consent to Chiropractic Adjustments and Care

PLEASE READ AND SIGN BELOW:

I hereby authorize this office to examine and treat my condition as they deem appropriate through the use of Chiropractic Health Care, and I give my authority for these procedures to be performed. I understand that I may obtain copies of my medical file upon request, and that copying fees may apply for these records.

In addition, my signature below acknowledges my Patient Consent for Use and Disclosure of Protected Health Information in accordance with HIPPA guidelines. I've had an opportunity to ask questions regarding its content.

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of Physical Therapy, on me (or on the patient named below, for whom I am legally responsible) by Dr. Dunn and/or other Licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for any Doctor of Dunn Chiropractic.

I have had an opportunity to discuss with the Doctor and/or with other office or clinic personnel the nature and purpose of Chiropractic adjustments and other procedures. 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. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, 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 upon the facts then known, is in my best interests.

Chiropractic treatment involves the Science, Philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptoms, disease or condition as a result of treatment in this clinic. I understand that the Chiropractor will use his hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click." It is my intention to rely on the Doctor to exercise professional judgment during the course of any procedures, which he or she feels at the time to be in my best interest. Neither the practice of Chiropractic or Medicine is an exact Science, but relies upon information related by the patient, information gathered during examination, and the Doctor's interpretation thereof, as well as the Doctor's judgment and expertise in working with like cases.

I understand that as part of my Healthcare, this practice originates and maintains Health records describing my Health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other Health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing 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's (or Parent/Legal Guardian's) **Signature**:_____

Patient's **Printed** Name:_____ Dated:_____/_____/_____

*Doctor's Signature:*_____ Dated: _____/_____/_____

Billing Statement and Policy for Dunn Chiropractic

Payment is expected in full at the time of service unless financial arrangements have been made with the office manager or doctor prior to having an adjustment.

Insurance (out of network)

We will file insurance for you; however, the insurance company will pay you directly once the deductible has been met and the visit limit or annual maximum has not been exceeded which is based on your chiropractic insurance coverage. You will still be expected to pay in full for all charges at the time of service. We will only be paid directly by insurance companies under the following conditions; car accident, workman's compensation, and Medicare with supplement insurance.

Anthem-BCBS

Dunn Chiropractic is considered an in-network provider for BCBS. Your benefits/eligibility, coverage, and copayments are based on your chiropractic insurance policy. If your insurance denies any charges, you will be responsible for those bills not covered. You are expected to pay copayments at the time of service. As a service, we will check on your coverage for you.

Medicare Insurance

Medicare insurance will be submitted on a participating basis. We do accept assignment. This means we will send all claims to Medicare unless specified by patient. If Medicare denies any services, you will be responsible for those bills not covered by Medicare or Supplemental Insurance. Some charges that are NOT covered by Medicare are: x-rays, extremity adjustments (legs-arms), examinations, all therapies, vitamins, braces, etc.

NO SHOW POLICY

If you do not show up for your appointment, we will charge you a $25 "no show fee".

I have read and understand the above statement for the billing policy of Dunn Chiropractic.

_____

Signature

_____

Date

THIS PAGE IS FOR OFFICE USE ONLY:

Blood Pressure:

_______ Insurance Card(s) Match File _______ Name & Address Matches DL/Ins.

_______/______ Measured: Standing/Sitting Using: Right/Left Arm/Leg_____________

_______/______ Measured: Standing/Sitting Using: Right/Left Arm/Leg_____________

Height: Weight: George's Test:

_______Ft. ___________In. _______lbs. Negative ______ Positive (signs)_______

Demeanor:

Alert/Oriented Agitated Distressed Guarded Obesity Requires Assistance___________

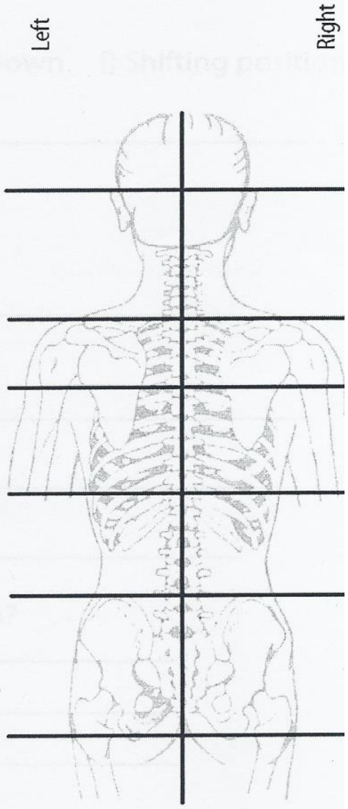
Rate your pain in each area using the following scale. (You may select a range as in the example.)

How often do you experience pain?

Describe the type of pain you are experiencing.

Mark the area(s) that you are experiencing pain using a circle or X.

	NO PAIN — MODERATE PAIN — MOST SEVERE PAIN	Constant (100%-76%)	Frequent (75%-51%)	Occasional (50%-26%)	Intermittent (25%-0%)	Dull Ache	Tightness	Tingling	Shooting	Numbness	Burning	Sharpness	Discomfort	Other- Describe
EXAMPLE	0 1 (2)—3—4—(5) 6 7 8 9 10													
Headaches	0 1 2 3 4 5 6 7 8 9 10													
Neck	0 1 2 3 4 5 6 7 8 9 10													
Upper Back	0 1 2 3 4 5 6 7 8 9 10													
Mid-Back	0 1 2 3 4 5 6 7 8 9 10													
Lower Back	0 1 2 3 4 5 6 7 8 9 10													
Pelvis	0 1 2 3 4 5 6 7 8 9 10													
Other	0 1 2 3 4 5 6 7 8 9 10													



Specify the Area:_________________________________

Other Notes:

____

____

____

History/Exam Reviewed By: ____Date:_____/___/______