



Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
Print Name

Consent to evaluate and adjust a minor child (if applicable):

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature

Date

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

Signature

Date

The following information is needed in order to better serve you. Please complete all questions.

Last Name _____ Middle Name _____ First Name _____
Nick Name _____ SSN _____

Address _____
City _____
State _____ Zip Code _____
Email _____
Home Phone _____
Work Phone _____
Cell Phone _____

Gender Male Female
Birth Date _____
Occupation _____
Employer _____
Employer's Address _____
Marital Status Divorced Single Married

How did you hear about us? Self Referral Yellow Pages Screening Website Print Ad
 TV Ad Radio Existing Patient _____

Spouse's Name _____ Phone Number _____ Occupation _____
Spouse's Employer _____ Employer's Phone Number _____
Employer's Address _____

Primary reason for visiting our office _____

The following information is needed in order to better serve you. Please complete all questions.

Please describe your main complaint:

Please describe how and when this problem began:

Which of the following makes the symptoms better?

Rest Heat

Medication Stretching

Sitting Ice

Laying Down Walking

Standing Movement

Other _____

Which of the following makes the symptoms worse?

Rest Heat

Medication Stretching

Sitting Ice

Laying Down Walking

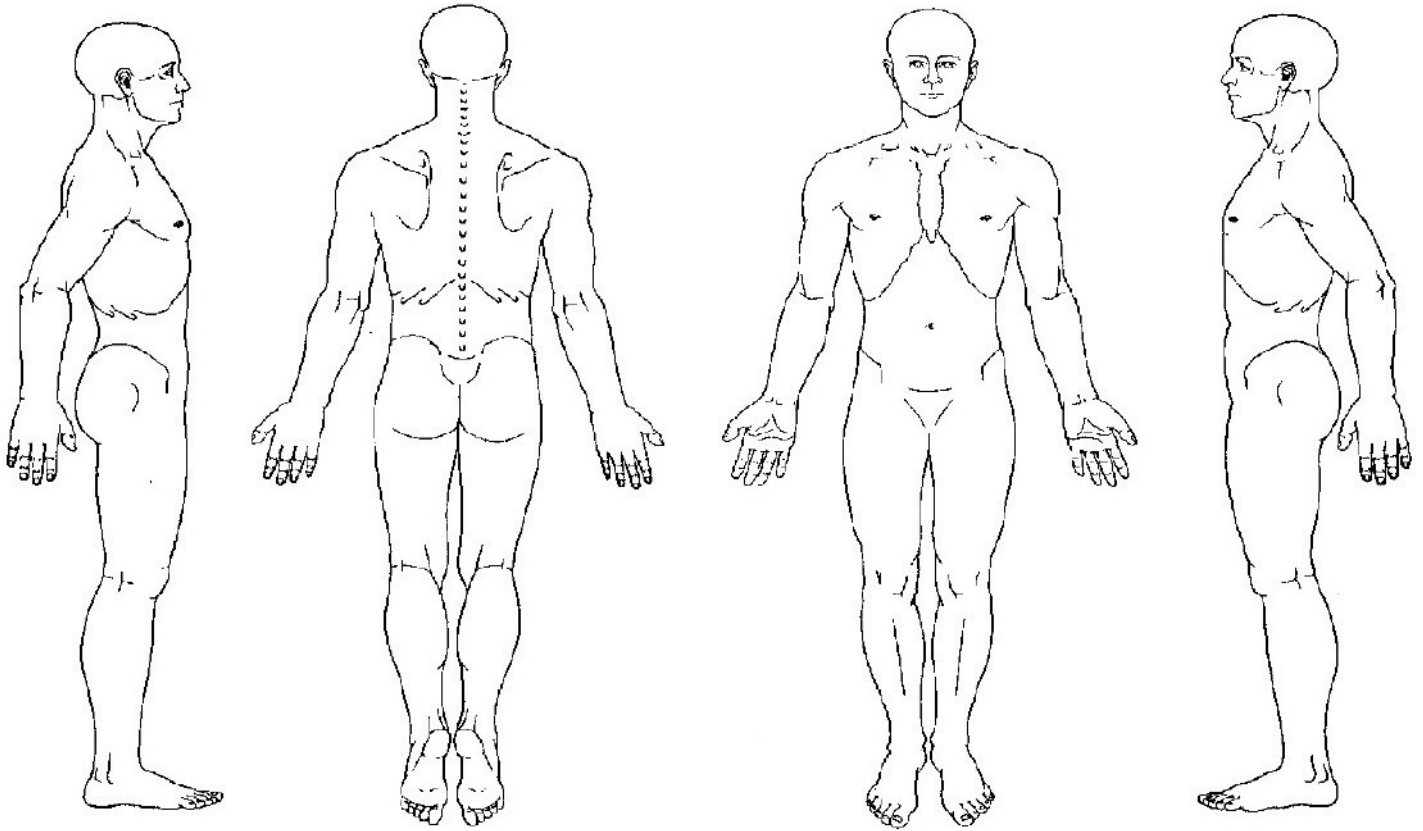
Standing Movement

Other _____

Describe your symptoms	How often do you experience your symptoms?	Do the symptoms radiate anywhere?	How severe are the symptoms?	When do you experience these symptoms?
<input type="checkbox"/> Sharp	<input type="checkbox"/> Constant (100-75%)	<input type="checkbox"/> Neck	<input type="checkbox"/> Minimal	<input type="checkbox"/> Morning
<input type="checkbox"/> Achy	<input type="checkbox"/> Frequent (75-50%)	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Mild	<input type="checkbox"/> Afternoon
<input type="checkbox"/> Burning	<input type="checkbox"/> Intermittent (50-25%)	<input type="checkbox"/> Arms	<input type="checkbox"/> Moderate	<input type="checkbox"/> Evening
<input type="checkbox"/> Stabbing	<input type="checkbox"/> Occasional (25-1%)	<input type="checkbox"/> Fingers	<input type="checkbox"/> Severe	<input type="checkbox"/> All the time
<input type="checkbox"/> Pins/Needles		<input type="checkbox"/> Leg		<input type="checkbox"/> Sporadically
<input type="checkbox"/> Fatigue		<input type="checkbox"/> Knee		
<input type="checkbox"/> Dizziness		<input type="checkbox"/> Ankle		
<input type="checkbox"/> Dull		<input type="checkbox"/> Toes		
<input type="checkbox"/> Other _____				

Indicate the location and the type of symptom that you are experiencing.

Numbness	=====	Burning	xxxxxx
Pins/Needles	ooooo	Stabbing	/////
_____	^^^^^ (Please describe the symptom)	Aching	aaaaa



Please indicate the region of pain (ie. shoulder, legs, etc.) and its severity, with 10 being incapacitated.

1 2 3 4 5 6 7 8 9 10
 Region: _____

1 2 3 4 5 6 7 8 9 10
 Region: _____

1 2 3 4 5 6 7 8 9 10
 Region: _____

1 2 3 4 5 6 7 8 9 10
 Region: _____

Please check the conditions you have or have had:

- | | | | | | |
|------------------------------------|--|-------------------------------------|--|---|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Autism | <input type="checkbox"/> Depression | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |

Please check all that apply:

- | | | | |
|---|--|--|--|
| <p>General History</p> <input type="checkbox"/> Trauma/Injuries
<input type="checkbox"/> Weight Changes
<input type="checkbox"/> Height Changes
<input type="checkbox"/> Fever/Chills/Sweats
<input type="checkbox"/> HIV Positive
<input type="checkbox"/> Allergies
<input type="checkbox"/> Anemia
<input type="checkbox"/> Bleeding/Bruising
<input type="checkbox"/> Malaise/Fatigue/Weakness | <p>Endocrine System</p> <input type="checkbox"/> Heat / Cold Intolerance
<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Extreme Fatigue
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hormone Therapy | <input type="checkbox"/> Sinusitis
<input type="checkbox"/> Other nose problems
<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Change in Voice
<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Enlarged Painful Glands
<input type="checkbox"/> Change in ability to taste
<input type="checkbox"/> Dental Problems
<input type="checkbox"/> Growth/Lesions in Mouth
<input type="checkbox"/> Other | <input type="checkbox"/> Diarrhea/Constipation
<input type="checkbox"/> Hernia
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Gallbladder Problems
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Alcohol Intake
<input type="checkbox"/> Anemia |
| <p>Family History</p> <input type="checkbox"/> Diabetes
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Musculoskeletal Disease
<input type="checkbox"/> Cancer
<input type="checkbox"/> Obesity | <p>Eye/Ear/Nose/Throat</p> <input type="checkbox"/> Visual Problems
<input type="checkbox"/> Eye Irritation
<input type="checkbox"/> Eye Pain
<input type="checkbox"/> Other Eye Problems
<input type="checkbox"/> Difficulty Hearing / Deaf
<input type="checkbox"/> Ringing in Ears/Dizziness
<input type="checkbox"/> Ear Pain
<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Obesity
<input type="checkbox"/> Change in ability to smell
<input type="checkbox"/> Sneezing
<input type="checkbox"/> Nose growths/Discharge
<input type="checkbox"/> Nose pain | <p>Gastrointestinal System</p> <input type="checkbox"/> Change in Appetite
<input type="checkbox"/> Food Intolerance
<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Peptic Ulcer
<input type="checkbox"/> Indigestion/Heartburn
<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Abdominal Swelling
<input type="checkbox"/> Gas
<input type="checkbox"/> Change in Stool Color | <p>Respiratory System</p> <input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Persistent Cough
<input type="checkbox"/> Blood in Sputum
<input type="checkbox"/> Wheezing/Asthma
<input type="checkbox"/> Tuberculosis/Exposure
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Lung Infection
<input type="checkbox"/> Lung Trauma
<input type="checkbox"/> Smoking Tobacco
<input type="checkbox"/> Smoking Other
<input type="checkbox"/> Toxic Fume Exposure |

Examiner's Notes:

Please check all that apply:

Cardiovascular System

- Shortness of Breath
- Chest Discomfort/Pain
- Palpitations
- Edema/Swelling
- Fainting
- Calf pain while walking
- High Blood Pressure
- Heart Disease
- Cardiovascular Surgeries
- Other Problems

Urinary System

- Frequent Urination
- Painful Urination
- Changes in Color
- Difficulty Starting
- Difficulty Holding
- Discharge
- Urinary Tract Infection
- Kidney Disease
- Flank Pain
- Pelvic Pain
- Pelvic Mass
- Other Problems

Breasts

- Bumps/Lumps/Tenderness
- Dimples in Breast
- Changes in Color/Size
- Nipple Discharge
- Other Problems

Reproductive System

- Genital Lesions/ Sores
- Genital Mass/Growth/Pain
- Syphilis
- Prostate Exam in Last Year
- Gonorrhea
- Change in Sex Drive
- Pain During Sex
- Birth Control
- Other Sexual Difficulties

Skin/Hair/Nails

- Change in Skin Temperature
- Change in Skin Texture
- Skin Dryness/Wetness
- Unusual Skin Coloration
- Rashes/Itching/Sores
- Skin Growths

Mole Changes

- Skin Cancer
- Skin Pain
- Changes in Hair Texture
- Changes in Hair Growth/Loss
- Change in Shape of Nails
- Change in Colors of Nails
- Other Problems

Neurological System

- Headaches
- Epileptic Seizures
- Tics/Spasms
- Dizziness/Fainting
- Disturbances of Sensation
- Unusual Weakness
- Head Trauma
- Stroke
- Change in Skin Temperature
- Difficulty Swallowing
- Difficulty Breathing
- Digestive Problems
- Irritable Bowels
- Fatigue
- Widespread Pain

Musculoskeletal System

- Joint Stiffness
- Joint Pain
- Joint Swelling
- Muscle Cramps
- Muscle Weakness
- Muscle Wasting
- Neck Pain
- Midback Pain
- Lowback Pain
- Tailbone Pain
- Arm Problem
- Fractures/Dislocations
- Leg Problems
- Sprains/Strains
- Other Injuries

Psychological History

- Anxiety
- Depression
- Hospitalization/Therapy
- Other Problems

Examiner's Notes:

Use this space to further describe any of the conditions /symptoms listed previously or any condition other than that for which you are now consulting us:

For female patients only:

Menarche (1st period) Age _____ Year _____ Days in Cycle _____

Menstrual Cramping Pain Menstrual Flow Duration _____

0 1 2 3 4 5

 Scant Light Moderate Heavy

- Post menopausal bleeding
- Abdominal/Painful premenstrual fluid retention
- Other female problems
- Difficult delivery
- PMS
- Hysterectomy

Examiner's Notes:

Please fill out all applicable fields:

List any other doctors, treatments, and results obtained:

Have you ever been unconscious, if so explain:

List all surgeries and there dates:

List any broken bones or dislocations:

List any traumas and their dates: (especially any head and neck injuries)

Please list all medications you are currently taking (prescription or OTC) and the reason for taking them:

Name of Medication	Reason for taking medication

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at this clinic we may use or disclose personal and health related information about you in the following ways:

- Your health care records will be reviewed by members of this clinic's staff who are involved in the administration of patient care.
- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering service or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, or, if you would like the information in a specific form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.



Notice of Privacy Practices

Continued

If you have a complaint or would like further information regarding our privacy notice, our privacy practices or any aspect of our privacy activities, please contact our privacy officer:

Katie DeMeester
Alive Chiropractic Center
303-601-9986

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W. Washington, D.C. 20201. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of October 1, 2004. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Please Print)

Signature

Date

If you are a minor, or if you are being represented by another party:

Name (Please Print)

Signature

Date

Description of the authority to act on behalf of the patient