

Welcome to
Colorado Chiropractic & Muscle Care

Dr. Bryce E. Christianson

Patient Information

Today's Date _____

Thank you for choosing us for your chiropractic and ART needs. Please complete this form in ink. If you have any questions please ask for assistance. We are happy to help.

Name: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: Female Male Birthdate: _____ E-mail: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Married Widowed Single Minor Separated Divorced Partnered for ____ years

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ City: _____ State: _____ Zip Code: _____

Spouse or parent's name: _____ Employer: _____ Work Phone: (____) _____

Whom may we thank for referring you to us? _____

If you were referred to us by another health care provider(s), do you consent to us communicating and obtaining records from their facility? Yes No Can we mail them a 'Thank You' card? Yes No

Person to contact in case of emergency: _____ Phone: (____) _____

Responsible Party

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Name of employer: _____ Work Phone: (____) _____ Work fax: (____) _____

How do you intend on paying for your services? (Please place an X)

_____ Cash _____ Health Insurance _____ Personal Injury/Auto Accident _____ Worker's Compensation

If this is a worker's compensation injury: Have you filed work comp paperwork? Yes No Claim #? _____

Who is your employer's safety supervisor: _____ Phone: (____) _____

If this is an auto accident: Are you at fault Yes No Claim #: _____ Insurance responsible: _____

Do you plan on using insurance? Yes No **If Yes, please give all cards to the front desk**

Health Goals

Reasons for visit: 1: _____ When did you first notice the symptoms? _____

2: _____ When did you first notice the symptoms? _____

Are your conditions getting progressively worse? _____ Where specifically is the problem(s) located? _____

What activities or motions irritate your symptoms? _____

What decreases your symptoms and what have you already tried? _____

Are any of your injuries related to: Personal Injury/Auto Accident Work-related injury None of these

Which activities are difficult to perform? Sitting Standing Walking Bending Lying down Other

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other

Are your symptoms radiating down your arms or legs yet? Yes No

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What are your goals for treatment? _____

What treatment have you received for your condition? Medication Surgery Physical Therapy Other _____

Name(s) of other doctor(s) or therapist(s) who have treated you for your condition: _____

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Health History Check only those conditions which are applicable:

- | | | | | |
|---|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostrate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke | _____ |

Dates of last exams: _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

List any types of surgeries which you have had and the dates which they occurred: _____

Please list all medications you are currently taking, and for what: _____

Daily Habits

What type of exercise do you perform on a daily basis? None Moderate Heavy

What do your daily work habits include? _____

What vitamins do you currently take? _____ Nutritional supplements (if any)? _____

Do you smoke? Yes No How much per day? _____

How much liquor do you consume weekly? _____ How many caffeinated beverages do you consume daily? _____

Consent to Treatment, Care and Treadmill Gait and Foot-Strike Analysis

I hereby request and consent to the performance of medical services, examinations, chiropractic adjustments and other procedures (including various modes of physiotherapy, ART and diagnostic x-ray) on me (or the patient named below, for whom I am legally responsible for) by the doctors and staff of Colorado Chiropractic & Muscle Care, and/or other licensed clinic doctors working at the clinic. I have had an opportunity to discuss with the doctor and/or with other office staff the nature and purpose of medical services and examinations, chiropractic adjustments, and other procedures. I authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I also understand my responsibility to inform this office of any changes in my medical status. I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of my treatment for my present condition and for any future condition(s) for which I seek treatment. **I consent to treadmill gait and foot-strike analysis and assume all risks involved using a treadmill. I will ask for and accept instructions if I need help using the treadmill** _____ Initials

Signature of Patient or Legal Guardian

Date

Printed Name of Patient or Legal Guardian

Relationship to Patient

Office Policies – please initial here _____ after you’ve read this information.

We do our best to keep an accurate and timely schedule and we expect the same from our patients. We require 24 hours notice to change appointment times and dates. Patients are charged \$25 when they miss scheduled appointments without **calling** to change appointments.

All bank services fees associated with a “bounced check” are directly billed to the patient plus a \$25 accounting fee.

Do you want us to communicate with you by email? Yes No By text messaging? Yes No

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