Comprehensive Chiropractic
1890 S Wadsworth Blvd
Lakewood CO 80232
Phone: 720-458-0487 Fax: 720-458-0981
comprehensivecolorado.com

New Auto Patient Intake

Name: _____

Preferred Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Home:_____ Cell:_____

Email: _____

Gender: _____Marital Status: _____Children: _____

Occupation:_____

Employer:_____

Emergency Contact:

Name:_____

Phone:_____

How Did You Hear About Us?_____

Have You Been To A Chiropractor Before?

_____

Do you have Medical Records or Imaging you would like us to look at? _____

<u>Your Auto Insurance Information:</u>

Company: _____ Policy #:_____

Name on policy: _____ MedPay Claim #: _____

Adjustor Name: _____ Adjustor Phone: _____

<u>At Fault Auto Insurance Information:</u>

Company: _____ Policy #: _____

Name: _____ Claim #: _____

Adjustor Name: _____ Adjustor Phone: _____

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History of Accident

Date of Accident:_____ Time of day:_____ Weather Conditions: _____

Location of accident (street/city/state): _____

Were you the driver/passenger, front seat/back seat? _____

Your approximate speed at impact? _____ Other Vehicle's Speed? _____

Were you aware of the impending impact? _____ Where were you looking? _____

Were you wearing a seatbelt?_____ Did the Airbag Deploy? _____ Did you hit your head? _____

Did any part of your body hit something? _____Did you lose consciousness? _____

Description of the accident

_____

_____

_____

_____

_____

_____

_____

_____

_____

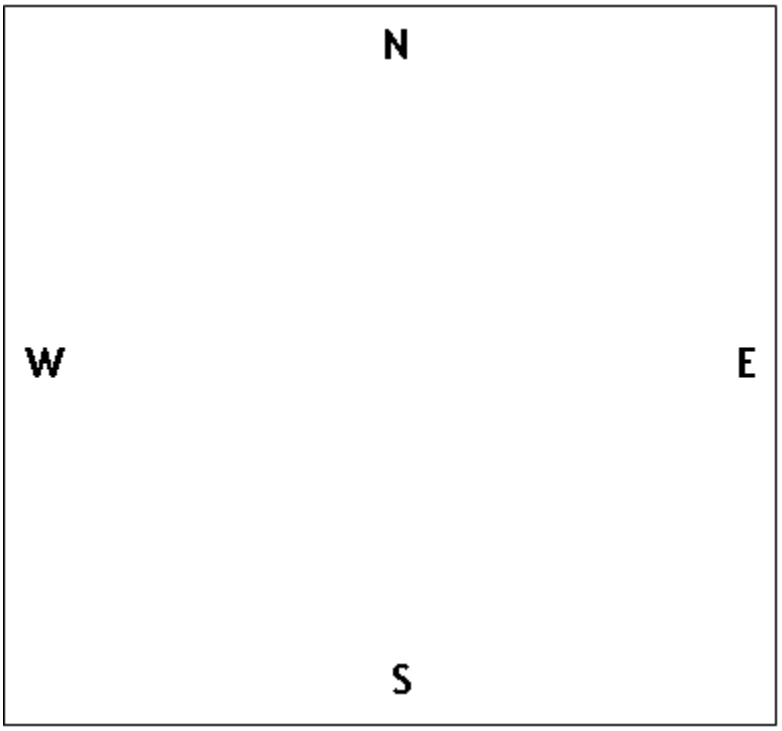
_____

_____

_____

_____

Diagram of the accident



Did you take photos? _____ Cost of repairing your car? _____

Year/Make/Model of your car? _____

Did the police arrive? _____ Did anyone receive a citation? _____

Did anyone get taken to the emergency room (if yes, who?): _____

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Current Conditions

(continue on the next page for multiple areas of the body)

First Complaint:_____

Is this complaint due to an accident? (circle one) Yes / No / Auto / Work / Home / Other

When did the complaint begin: _____ Is it constant or does it come and go?_____

Did it start gradually or suddenly? _____

How did this complaint begin? _____

_____

Have you had this complaint before? _____

What would you rate you pain right now on a scale of 1 -10 (10 being the worst)?_____

What would you rate you pain at its best on a scale of 1 -10 (10 being the worst)? _____

What would you rate you pain at its worst on a scale of 1 -10 (10 being the worst)? _____

When is the pain at its worst? (circle) Morning / middle of the day / end of the day / sleeping

Quality of the complaint (sharp/stabbing/burning/achy/dull/stiff/sore/electric/tingling/other)

_____

Does the complaint radiate/shoot to any area of the body? (if yes please explain)

_____

What makes the complaint better?_____

What makes the complaint worse?_____

What activities of your daily life are being affected by this condition?

_____

Is the complaint getting better, worse, or staying the same? _____

Do you have any imaging (x-ray/MRI) of the area? (date & type) _____

What treatment have you already received for the complaint? _____

Were you satisfied with the results of your treatment? _____

Current Medications:

Name	Dose	Date Prescribed

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(if you need more complaint pages please ask at the front desk)

Second Complaint: _____

Is this complaint due to an accident? (circle one) Yes / No / Auto / Work / Home / Other

When did the complaint begin: _____ Is it constant or does it come and go?_____

Did it start gradually or suddenly? _____

How did this complaint begin? _____

_____

Have you had this complaint before? _____

What would you rate you pain right now on a scale of 1 -10 (10 being the worst)?_____

What would you rate you pain at its best on a scale of 1 -10 (10 being the worst)? _____

What would you rate you pain at its worst on a scale of 1 -10 (10 being the worst)? _____

When is the pain at its worst? (circle) Morning / middle of the day / end of the day / sleeping

Quality of the complaint (sharp/stabbing/burning/achy/dull/stiff/sore/electric/tingling/other)

_____

Does the complaint radiate/shoot to any area of the body? (if yes please explain)

_____

What makes the complaint better?_____

What makes the complaint worse?_____

What activities of your daily life are being affected by this condition?

_____

Is the complaint getting better, worse, or staying the same? _____

Do you have any imaging (x-ray/MRI) of the area? (date & type) _____

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Past Medical History

Do you have any pre-existing diagnosed conditions? _____

_____

Do you have any allergies? (medications/other) _____

_____

Have you had any surgeries? (date/reason) _____

_____

Have you had any hospitalizations? (date/reason) _____

_____

Major Injury/Traumas (date/cause) _____

_____

Family Health History

Do any of your immediate relatives have any major health problems? (cancer/diabetes/heart disease/ stroke/auto immune disease) _____

_____

Social History

Hobbies: _____

Exercise: _____

Diet: _____

Tobacco: (never / quit / current) _____

Alcohol: (Drinks per week) _____

Coffee/Tea: _____

Recreational Drug use: _____

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Review of Systems

Are you currently experiencing any of these symptoms? (Circle all that apply)

Many of the following conditions respond to Chiropractic treatment

Constitutional

- Recent Weight Change
- Fever
- Fatigue
- None

Musculoskeletal

- Low Back Pain
- Mid Back Pain
- Neck Pain
- Arm Problems
- Leg Problems
- Painful Joints
- Stiff/Swollen Joints
- Weak muscles
- Broken Bones_____
- Other_____
- None

Neurological

- Numbness or Tingling Sensation
- Loss of Feeling
- Dizziness or Light Headed
- Frequent or Recurrent Headaches
- Convulsions or Seizures
- Tremors
- Stroke
- Have you ever had a head injury? Y / N
- Have you ever had an auto accident? Y / N
- Other:_____
- None

Mind/Stress

- Nervousness
- Depression
- Sleep Problems
- Memory Loss or Confusion
- Other_____
- None

Genitourinary

- Sexual Difficulty
- Kidney Stones
- Burning/Painful Urination
- Change in force/strain w Urination
- Frequent Urination
- Blood in Urine
- Incontinence or Bed Wetting
- Other:_____
- None in this Category

Gastrointestinal

- Loss of Appetite
- Blood in Stool
- Change in Bowel Movement
- Painful Bowel Movements
- Nausea or Vomiting
- Abdominal Pain
- Frequent Diarrhea
- Constipation
- Other_____
- None

Cardiovascular

- Chest Pains
- Rapid or Irregular Heart Beat
- Blood Pressure Problems
- Swelling of Hands, Ankles, Feet
- Other_____
- None

Respiratory

- Difficulty Breathing
- Persistent Cough
- Coughing Blood
- Asthma or Wheezing
- Lung Problems
- Other:_____
- None

Eyes and Vision

- Wear Contacts or Glasses
- Blurred or Double Vision
- Glaucoma
- Eye Disease or Injury
- Other_____
- None

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Ears, Nose, and Throat

- Bleeding Gums or Sores
- Bad Breath or Bad Taste
- Dental Problems
- Swollen Throat
- Swollen Glands in Neck
- Ringing in the Ears
- Ear- Ache/Drainage
- Sinus Problems
- Nose Bleeds
- Hearing Loss
- Other_____
- None

Endocrine, Hematological, and Lymphatic

- Thyroid Problems
- Diabetes
- Excessive Thirst or Urination
- Cold Extremities
- Heat or Cold Intolerance
- Change in Hat or Glove Size
- Dry Skin
- Swollen Glands
- Anemia
- Easily Bruised or Bleeding
- Phlebitis
- Transfusion
- Immune System Disorder
- Other_____
- None

Skin and Breasts

- Rash or Itching
- Change in Skin Color
- Change in Hair or Nails
- Changes of Mole
- Non-healing Ulcer
- Breast Pain
- Breast Lump
- Breast Discharge
- Other_____
- None

Women Only

Are you pregnant?
Yes - Due Date ____/____/____
No - First Date of Last Menstrual Period ____/____/____

- Infertility
- Painful or Irregular Periods
- Vaginal Discharge
- Other_____
- None

Pregnancies with Outcome and Date:

_____
_____
_____

Please list any additional Problems: _____

_____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date: ____/____/____

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Assignment of Benefits / Release of Records

I authorize my automobile insurance company to make payments to Comprehensive Chiropractic P.C. for all services provided by Comprehensive Chiropractic P.C. I give permission for Comprehensive Chiropractic P.C. to release my medical records to my insurance company if requested. I understand that I am responsible for all products/services provided to me, including the balance remaining from the insurance company. If my insurance does not pay, I will be responsible for the full payment of the balance. I understand that payment for healthcare services is not contingent on any settlement, judgment, etc. I am obligated to pay the full amount of all bills regardless of the outcome of my personal injury claim.

Patient/Guardian Signature: _____ Date: _____

CANCELLATION POLICY

We ask that you provide us with a 24 hour notice if you need to cancel any appointment. Notice can be given with an email, call, or text reply to your appointment reminder. Because the room is reserved for you personally, a cancellation fee of $25 will apply to your next visit for all no call/no show visits.

Patient/Guardian Signature: _____ Date: _____

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy modalities such as: Instrument Assisted Soft Tissue Technique, Therapeutic Ultrasound, Myofascial Release, Spinal Decompression, Rehabilitation, on me (or the patient named below, for whom I am legally responsible including a minor) by the doctor of chiropractic named below 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 the doctors of chiropractic named below.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some minor risks to treatment, including, but not limited to, fractures, disc injuries, strokes, burns, bruises, soreness, 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 on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, and is my best interest. There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment. Cauda Equina Syndrome occurs when a space occupying lesion in the spinal cord of the low back puts pressures on the nerves that control the bowel, bladder, and sexual functions. If you have any of these symptoms, tell us immediately, and if we can't be reached, go the emergency department.

I have read, and or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and 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.

FUNCTIONAL DRY NEEDLING INFORMED CONSENT

I understand and I am informed that, in Functional Dry Needling there are some risks to treatment, including, but not limited to, accidental puncture of a lung (pneumothorax). This is a rare complication, and in skilled hands it should not be a major concern. Other risks include bruise, infection, and/or nerve injury.

I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My doctor has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. This consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below

_____
Printed Name of patient

_____
Signature of patient or Guardian

_____
Date signed

Treating Doctors:

Dr. Roxanne Wagner D.C **Dr. Bradley Knox D.C.**

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HIPAA Notice of Privacy Practices

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

Our Obligations
We are required by law to:
• Maintain the privacy of protected health information
• Give you the notice of your legal duties and privacy practices regarding health information about you
• Follow the terms of our notice that is currently in effect
How We May Use and Disclose Health Information:
Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose health information only with your written permission. You may revoke such permissions at any time by writing to our practices privacy officer.
Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.
Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for treatment and services you receive. For example, we may give your health plan information so that they will pay for your treatment.
Health Care Operations: We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We also may share information with our entities that have a relationship with you (for example, your health plan) for their health care operation activities.
Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services: We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.
Individuals Involved in Your Care or Payment for Your Care: When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.
Research: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who receive one treatment to those who receive another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes.
Special Situations: As required by law. We will disclose Health Information when required to do so by international, federal, state, or local law.
To Avert a Serious Threat to Health of Safety: We will disclose Health Information when necessary to prevent a serious threat to your health and safety or the public, or another person. Disclosure, however, will be made only to someone who may be able to help provide treatment.
Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or to provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than that as specific in our contract.
Organ and Tissue Donation: If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation, and transplantation.
Military and Veterans: If you are a member of the army forces, we may use or release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.
Workers' Compensation: We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
Public Health Risks: We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.
Health Oversight Activities: We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

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Lawsuits and Disputes: If you are involved in a lawsuit of a dispute, we may disclose Health Information in response to a court or a court administrator order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of crime even if, under certain circumstances, we are unable to obtain the persons agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises and; 6)in an emergency to report a crime to the location of the crime if victims, or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, Funeral Directors: We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities: We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations. Protective Services and Intelligence Activities. We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody: If you are an inmate of a correctional institution or other custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others, or; 3) for the safety and security of the correctional institution.

Your Rights

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy: You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer.

Right to Amend: If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our Privacy Officer.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our Privacy Officer.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operation. You also have a right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. We are not required to agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication: You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.

Changes to This Notice: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a current copy of our notice at our office. The notice will contain the effective date on the first page, in the top right hand corner.

Complaints: If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

By signing my name below, I acknowledge receipt of a copy of this notice if wanted, and my understanding and my agreement to its terms.

_____ _____

Patient Signature Date