3600 South Wadsworth Blvd. Lakewood, CO, 80235
303-985-0646

A Better Back Clinic
Serving your chiropractic needs since

Patient Information Form

Name: _____ (Nick name?) _____

Address: _____ **City** _____ **St** _____ **Zip** _____

Phone: Home:_____ Work _____ Cell _____

(Best number to contact you?) Home Work Cell **Social Security** #_____

Email Address: _____

Birth Date _____ **Age** _____ **Sex**: M F **Circle one**: Single Married Partnered Widowed Divorced

Employer: _____ **Occupation:** _____

Spouse's Name: _____ **Spouse's Occupation:** _____

Children: Name and Ages _____

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Causative reason for consulting our office today: Auto accident? _____ (please let the front desk know)

Injury/Accident? _____ Unknown cause _____ Other (explain) _____

Problem began? Date _____ **OR** Gradually came in Y / N **OR** Old problem reoccurring Y / N

Health Practitioners you sought out for current or any other problem health concern: (Please check)

____ Chiropractor ____ Massage Therapist _____ Acupuncturist _____ Physical Therapist ____ Other:_____

____ G P / M D (M D Name _____ City _____ Ph _____)

Has a Chiropractor treated you before? Y / N

Name / Office _____ Date of last adjustment _____

Frequency of care _____ x per week/ month Duration of care _____ weeks/ months/ years

Brief reason for not returning to that Chiropractor _____

General Health Questions

Give approximate date of last: Blood Test _____ X-Ray _____ Physical _____ Hospitalized _____

What is your daily fluid intake: Coffee ____/day Alcohol ____/day Water ____/day Soda _____/day

Sleep/Rest Habits: Mattress age? _____Yrs Hours at night _____/Hrs Side ____ Back ____ Stomach ____

(Circle one) # of Pillows 1 / 2 / more Soft ____ Hard _____ Orthopedic? Y / N Pillow age _____Yrs

Exercise Habits (outside of work responsibilities) _____ x per week % Aerobic _____ / % Weights _____

Your play and relaxation activities _____

_____

Do You Use prescription, over the counter, and recreational drugs / medications? Y / N (if yes please list)

_____

_____

Signature: _____ **Date:** _____

Check symptoms or conditions below that you experience CURRENTLY or OCCASIONALLY:

☐ Headaches/ Migraines	☐ Wrist/ Carpal Tunnel	☐ Asthma	☐ Digestive Problems
☐ Neck Pain	☐ Shoulder	☐ Shortness of Breath	☐ Problem Sleeping
☐ Top of Shoulder Pain	☐ Elbow/ Arm Pain	☐ Ringing in Ear	☐ Allergies
☐ Mid-Back Pain	☐ Knee Pain	☐ Vertigo/ Dizziness	☐ Chest Pains
☐ Along Shoulder Blades	☐ Foot/ Ankle	☐ Loss of Balance	☐ High Blood Pressure
☐ Low Back Pain	☐ Toes/ Hands	☐ Low Energy/Fatigued	☐ Weight Trouble
☐ Hip/ Sacral Pain	☐ Numbness in Arms/ Hands	☐ Depression	☐ Menstrual Pain
☐ Leg / Sciatica Pain	☐ Numbness in Legs/Feet	**Other** _____	

Which of the above symptom(s) are **your MAIN concern(s)**? _____

Give START date or for how long have you had this/ these main concern(s)? _____

DESCRIBE the pain (i.e. sharp, achy, burns, tingles, etc.) _____

Any INJURIES/ accidents that stand out in your life _____

Any known more serious DISORDERS (i.e. diabetes, heart, stroke, cancer, etc.) _____

Any SURGERIES and give approximate year or your age? _____

Stress can contribute to any symptom along with poor health and diminished quality of life
Rate (**circle**) "Your overall perceived level of stress" Low Stress 1---2---3---4---5---6---7---8---9---10---High Stress

I, (Printed name) _____ **(Signature**) _____

Have read and completed the above information on _____ **(Date).**

(If the above information is related to a minor seeking care), I _____ (print name) being the parent or legal guardian of _____ (print name) has signed above to give permission for my child to receive any care including consent to evaluate and treat the minor and/or child.

(BELOW THIS LINE IS FOR OFFICE USE/PRACTITONER NOTES)

Area?	Description	Aggravates/Relievers?	Radiation?	Frequency?	Cause/Date	Pain Scale W/B

Payment Information:

(_____) I have insurance

*Primary Insurance Name: _____

*Secondary Insurance Name: _____

(*Must present current copy of insurance card for insurance to be confirmed and or billed)

(_____) I don't have insurance, I will be self-pay

As a courtesy, Complete Care Health Services will verify benefit coverage and bill your primary/secondary insurance. However, we will not be able to process your insurance claims unless all information has been provided by you, the patient. If all information is not provided you will be responsible for the remaining balance.
Again, we will assist you in obtaining payment from your insurance carrier, the responsibility for payment of all bills in connection with this clinic lies with the patient.
Payment is expected at the time of service, all Deductibles, Co-insurance, and Co-pays will be collected in full.

Assignment of Benefits and release of related medical records**

Consent to treatment or testing with liability release:

**You authorize Complete Care Health Services (CCHS), its authorized subsidiaries and technicians to administer treatment and/or testing. Furthermore, while the chance of injury is slim, you agree to hold CCHS and its staff without fault for any injuries that may occur during the procedures or advice you have had done for you. Special note to patients with breast augmentation, although rare there may be risk of implant rupture. Please advise your Chiropractic Physician before any manipulation procedures.

Verification of Non-pregnancy:

**You attest, to the best of your knowledge, that you are not pregnant, nor is the pregnancy suspected or confirmed at this particular time. If you think you might be pregnant, please advise your physician.

Release of Patient Records:

**You authorize CCHS to furnish your insurance carrier, attorney, and/or referring physician with documentation / reports relating to your, case history, examination, diagnosis, treatment, and prognosis. This release of records is pursuant to only the representative above, and only for the accident/illness for which you are being treated. Furthermore, CCHS has the right to release any and all records required for remuneration purposes. Fees relating to such records are the patient's responsibility.

Missed appointment notice:

If you cannot make an appointment and need to cancel, we require **24 hours advance notice. Should we not receive such notice a **$50.00** no show fee will be assessed to your account. This is a non-reimbursable fee that your insurance carrier does not pay and is your sole responsibility.

Returned checks:

All returned or unpaid checks will have a **$45.00 returned check fee assessed to your account.

Verification of information

**Any information asked of me are / will be accurately given. I understand that providing incorrect information can be dangerous to my health. I authorize CCHS to release any said information, including the diagnosis, the records of any treatment and/or examination rendered to me during my care, to a third party payer and/or healthcare practitioners.
I also authorize payment to be made directly to CCHS and the amount due for all service charges for myself or my eligible dependents. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible of all services rendered on my behalf or my dependents. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibilities of the person(s), including parent or legal guardian, named on the account.

I certify that I have read and understand the above information to the best of my knowledge

Signature_____ **Date**_____