Dr. Craig Pearson

2625 28th Street, Suite 100 Boulder, CO 80301 Phone: 303-402-1300 Fax: 303-402-1310

Today's Date: ________________________________

Patient Information: Referred by: ________________________________

Patient (Legal Name): ____

Patient Address: ____

City: ________________ State: ______ Zip Code: __________ Date of Birth: ________________

Home Phone: ______________________ Cell: ______________________ M or F Age: ________

E- mail Address: ________________________________ Social Security Number: ________________

Name of Emergency Contact: ______________________ Relationship: ______________

Address: ____ Phone number: ________________

Employment Information- Patient (18 or older) or Responsible Party:

Employer: ____ Occupation: ______________________

Employer Address: ____ Phone: ________________

Personal Information:

Major complaint: ____

Other complaints: ________________________ How long have you had this condition? ____________

Have you had this or similar conditions in the past? ________________________________

What makes your condition worse? ____________________________

What makes your condition better? ____________________________

Does it interfere with: Work Sleep Daily routine Other: ________________________________

How long has it been since you have felt good? ________________ Date of last physical exam: ________________

Have you received chiropractic care in the past? __________ If yes, where and when_________________________

Were X-rays taken? _________ Date X-rays were taken: _______________

Operations you have had: ________________________________ Serious illness: ___________________________

Are you currently seeing any other Health Care Providers?

Providers Name: ____ Specialty: ____________________________

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Are you wearing: Heel lifts Sole Lifts Orthotics

What type of accident(s) have you been in (e.g. auto, bicycle, pedestrian, skiing)? ____________________________

Describe: ____

Date(s) of accident(s): ________________________________

Drugs you take now: Painkillers Muscle Relaxers Anti-inflammatory Anti-depressants Tranquilizers

Birth Control Insulin Thyroid Medication Statins Anti-Coagulants

Supplements you are currently taking: Multi-vitamin Fish oils Vitamin D B vitamins Minerals

Calcium/Magnesium Anti-oxidants Exercise performance enhancers

Other: ____

Are you interested in nutrition and diet? Yes No

Would you like to talk with Dr. Pearson today about your daily, overall health in addition to your specific complaints? Yes No

Consent to Treatment: Please initial each statement.

______ I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations, and treatment at Canyon Chiropractic Center.

Release of Records:

______ I hereby authorize the release of medical records, or information necessary to process my claim, to my insurance company, adjuster, or attorney as applicable.

Financial Responsibility and Assignment of Benefits:

______ Payment is due at the time of service. Patients are ultimately responsible for all charges incurred by treatment in this office.

______ Canyon Chiropractic Center is not in network with insurance companies. All patients are encouraged to call the member services number on their insurance card to inquire about their plan coverage for chiropractic treatment and any associated deductibles, limitations, exclusions, precertification needs, pre-existing condition clauses, etc. Canyon Chiropractic Center can provide the appropriate forms containing diagnostic codes and prices for patients to submit to their insurance themselves. Patients are responsible for knowing their insurance benefits and limitations prior to scheduling appointments. **Insurance patients are ultimately responsible for all charges incurred by treatment in this office**.

______ In order to provide you and our other patients with optimal spinal care, we request that you follow our guidelines regarding broken/cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to complete their treatment. A $30 cancellation fee will be charged to your account if you either miss or cancel your appointment without the appropriate 24 hour notice. **I understand I will be charged for any appointments I miss if I do not give 24 hours cancellation notice without good cause.**

______ I hereby assign to this practice, Canyon Chiropractic Center, all monies to which I am entitled through insurance for treatment expenses relative to the service rendered by this practice, but not to exceed my indebtedness to said practice. It is understood that any monies received from the above named insurance company(s), over and above my indebtedness, will be refunded to me or my insurance company(s), as it is determined to be appropriate, when my bills are paid in full.

_____ I understand I am financially responsible to Canyon Chiropractic Center for all charges not covered by the above assignment. In the event I default, I agree to pay, whether or not legal proceedings are instituted, a reasonable COLLECTION FEE which shall be 18% per annum of the principal balance for any debt incurred hereunder and to pay all reasonable LEGAL COSTS as a result of my default.

I certify that I have read this form and understand its contents.

____ Date: ________________________

(Patient -18 or older- or other legally Authorized Person)

Check all of the following that you have had in the past six months:

Musculo-Skeletal System		Gastro-Intestinal System		General	
Low back pain		Poor or Excessive Appetite		Fatigue	
Pain Between Shoulders		Excessive Thirst		Allergies	
Neck Pain		Frequent Nausea		Loss of Sleep	
Arm Pain		Vomiting		Fever	
Joint Pain or Stiffness		Diarrhea		Headaches	
Walking Problems		Constipation			
Difficult Chewing		Hemorrhoids		**C-V-R**	
General Stiffness		Liver Problems		Chest Pains	
		Gall Bladder Problems		Short Breath	
Nervous System		Weight Problems		Blood Pressure Problem	
Nervousness		Abdominal Cramps		Irregular Heartbeat	
Numbness		Gas/ Bloating After Meals		Lung Congestion	
Dizziness		Heartburn		Varicose Veins	
Forgetfulness		Black or Bloody Stool		Ankle Swelling	
Confusion		Colitis		Stroke	
Depression					
Fainting		**EENT**		**Female**	
Convulsions		Vision Problems		Menstrual Irregularity	
Cold Extremities		Dental Problems		Vaginal Pain or Infection	
Stress		Sore Throat		Breast Pain or Lumps	
Weakness		Ear Aches		Date of last period:	
Male		Hearing Problems		Are you pregnant?	
Prostate Problems		Stuffed Nose		Yes: No: Unsure:	

Check the following practices that apply to you:

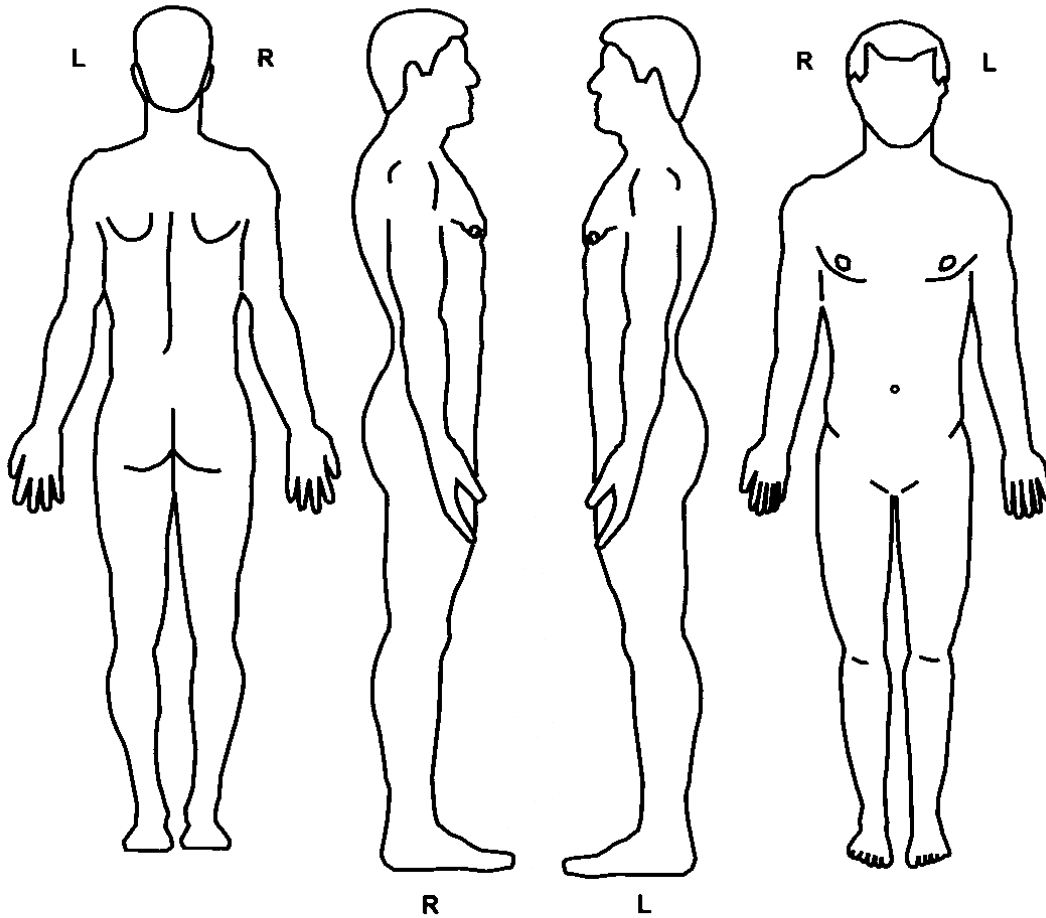
	Heavy	Moderate	Light	None		Heavy	Moderate	Light	None
Alcohol					Exercise				
Coffee					Sleep				
Tobacco					Appetite				
Drugs					Sugar				

Check yes or no in self column, and check those that apply to your family:

Condition	Self (Yes or No)	Father	Mother	Siblings	Children
Acid Reflux					
Anemia					
Arthritis					
Asthma/Hay fever					
Back Trouble					
Bursitis					
Cancer					
Constipation					
Diabetes					
Disc Problem					
Epilepsy					
Headaches					
Heart Disease					
High Blood Pressure					
Influenza					
Insomnia					
Kidney Trouble					
Liver Trouble					
Migraines					
Nervousness					
Pinched Nerves					
Pneumonia					
Polio					
Rheumatoid Arthritis					
Scoliosis					
Sinus Trouble					
Stomach Trouble					
Stroke					
Other:					

Sensation Diagram

Name: ______________________________ **Date:** ______________



Mark as Follows:
A- Ache B-Burning N-Numbess P-Pins & Needles S-Stabbing
O- Other Describe:____

____

____

<u>Please check the expectation of your care with us:</u>

Quick Fix (“Band-Aid”)	____________
Full Recover of Injury or Problem	____________
Lifestyle Change with Maintenance	____________

Patient Health Information Consent Form

We want you to know how your Patient Health Information **(PHI)** is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to all this chiropractic office to use their Patient Health Information **(PHI)** for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

______________________________	______________________________
Patient -18 or older- or other Legally Authorized Person	**Date**

CANCELLATION POLICY

In order to provide you and our other patients with optimal spinal care, we request at least **24 hours** notice in order to reschedule your appointment. Please remember that we have reserved appointment times especially for you. By allowing us at least 24 hours notice, it will enable us to offer your cancelled time to other patients that desire to complete their treatment. A $30 cancellation fee will be charged to your account if you either miss or cancel your appointment without the appropriate 24-hour notice. Thank you for your respect.

Release of Medical Information to Specific Person(s) (OPTIONAL):

I request and authorize Canyon Chiropractic Center to release medical information to the organization, agency, or individual named on this request.

I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Those receiving the authorized information without my further written consent may not disclose my medical information. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. **Below, please specify a date that you would like this consent to expire**.

Date consent is to **expire**: ____

Please release information to: ____

Relationship(s) to patient: ____

Signature of patient: ____

Additional Notes: