PARTNERS IN HEALTH, LLC

Spinal Manipulation · Dry-Needling · Physical Therapy
Massage Therapy · Traditional Acupuncture

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Tel: (303) 438 1600

CONFIDENTIAL NEW PATIENT INFORMATION

Please PRINT clearly and answer as accurately and as completely as possible. Fill out in black or blue ink only.
If you need help, please ask! Thank you!

NAME _____ _____
FIRST MIDDLE INITIAL LAST **TODAY'S DATE**

ADDRESS _____
STREET CITY STATE ZIP

DATE OF BIRTH _____ **SOCIAL SECURITY #** _____ **EMAIL**:_____
mm/dd/year

HOME PHONE # _____ **WORK PHONE #** _____ **CELL PHONE #** _____

☐ **MALE** ☐ **FEMALE** **MARITAL STATUS:** ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOWED** ☐ **CHILD**

INSURANCE CO. _____ **MEMBER ID#**_____ **GROUP #**_____

NAME ON INSURANCE CARD _____

RELATIONSHIP TO PERSON ON INSURANCE CARD: ☐ **SELF** ☐ **SPOUSE** ☐ **CHILD** ☐ **OTHER** _____

EMPLOYER _____ **OCCUPATION** _____

NAME OF PRIMARY CARE PHYSICIAN _____ **TELEPHONE #:** _____

HAVE YOU SEEN YOUR PRIMARY CARE PHYSICIAN FOR YOUR CURRENT PROBLEM? ☐ **YES** ☐ **NO**

HOW DID YOU FIND OUT ABOUT US? ☐ **MD** ☐ **FRIEND** ☐ **EVENT** ☐ **SIGN** ☐ **INTERNET SEARCH**

IF INTERNET SEARCH, WHAT MADE YOU DECIDE? ☐ **REVIEWS** ☐ **WEB SITE** ☐ **LOCATION** ☐ **OTHER**

Authorization to Release Medical Information

I authorize the release of medical information necessary to process my insurance claim(s) and also certify that all insurance and personal information given to this clinic is correct and complete.

Patient's signature: _____ Date: _____

INFORMED CONSENT

Chiropractic, TDN (tigger point dry-needling), acupuncture and masage are associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While these treatments are remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

We cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Treatment

Soreness - Chiropractic adjustments, physical therapy, massage, TDN and acupuncture procedures are sometimes accompanied by post-treatment soreness. This is a normal and acceptable accompanying response to treatment. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury - Occasionally treatments may aggravate soft tissue conditions temporarily. They can also cause minor ligament, tendon or muscle soft tissue injuries as well as bruises.

Rib Injury - Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is peformed carefully to minimze such risk.

Physical Therapy Burns - heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if it occurs, you should report it to your doctor.

Stroke - Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 4 million upper cervical adjustments.

TDN possible side effects - Dry needling may cause an increase in pain for one to three days followed by an expected improvement in the overall pain state. The increased pain is related to overactive shortened muscle bands that have not been released and to the soreness caused by the "twitching" of the muscles. Any time a needle is used there is a risk of infection. However, we are using new, disposable and sterile needles, and infections are extremely rare. A needle may be placed inadvertently in an artery or vein. If an artery or vein is punctured with the needle, a hematoma (or bruise) will develop. If a nerve is touched, it may cause paresthesia (a prickling sensation) which is usually brief, but it may continue for a couple of days. When a needle is placed close to the chest wall, there is a rare possibility of a pneumothorax (air in the chest cavity). Fortunately, **all these complications are not fatal and are readily reversible.** A gown is provided for female patients. However, for a proper and thorough examination and treatment, the gown may be opened up from the back or it may be partially moved by the practitioner. Care will always be taken to respect your privacy. **Patients are requested to inform practitioners about conditions such as pregnancy, pacemakers, and the use of blood thinners or immunosuppressant medications prior to the treatment.**

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered. I also authorize Dr. Peter Ray as well as any hired or contracted Doctor, assistants/therapists to perform diagnostic tests, including but no limited to x-rays, and to administer treatment as is necessary.

Patient's signature: _____ Date: _____

Parent/Legal Guardian: _____

<u>Consent for Treatment of a Minor – please fill out if the patient is a minor</u>

I hereby authorize the Doctors of Partners in Health, and whomever they designate as their assistants, to perform diagnistic tests, including but not limited to x-rays, and to administer treatment as they deem necessary to my (indicate relationship of child) _____, (child's name) _____.

Guardian's signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. **A full notice of your privacy rights is provided to you at the front desk.**

Partners In Health Inc. uses health information about you for treatment, to obtain payment for treatment with your authorization as required by state law for administrative purposes, and to evaluate the quality of care that you receive.

Partners In Health Inc. will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Partners In Health Inc. may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Partners In Health Inc. may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of you health records.

You may complain to the Privacy Officer, Dr. Peter Ray, and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Partners In Health Inc.must maintain the privacy of protected health information, provide your with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions of complaints please contact Dr. Peter Ray at 303 438 1600.

_____ _____

Patient Signature **Date**

EMERGENCY CONTACT INFORMATION:

Whom may we contact in case of an emergency?

Full Name: _____ Relationship: _____

Phone number: _____

Date: _____ Patient Name: _____

Is your condition the result of an accident**?** □ **YES** □ **NO** IF YES: Date: _____

Was it: □ **WORK RELATED** □ **CAR ACCIDENT** □ **SPORTS INJURY** □ **OTHER** _____

Please describe injury:

For the diagrams below, indicate the areas where you are experiencing pain or discomfort using the appropriate symbols.

SYMBOLS

/ / / /
/ / / / **sharp pain**

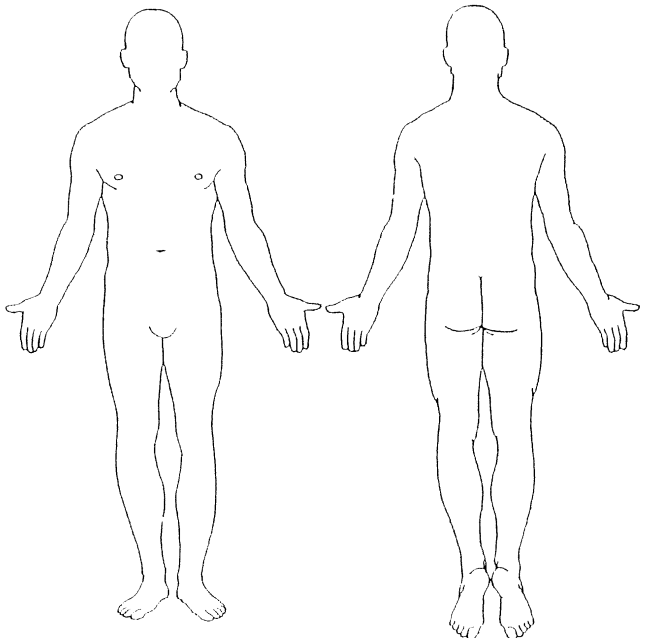
z z z
z z z **stiffness**

+ + +
+ + + **dull, achy pain**

o o o
o o o **pins and needles**

= = =
= = = **numbness**

x x x
x x x **burning**



DO NOT FILL OUT BOX BELOW

FOR OFFICE USE:

BP:_____/_____

TEMP: _____

WEIGTH: _____

HEIGTH: _____

On a scale of 1 –10, how much pain do you have now? (1 being the best ,10 being the worst) 1 2 3 4 5 6 7 8 9 10

Describe your complaint: _____

What brought on the pain? _____

How long have you had these symptoms? _____ Any previous similar episodes? _____

How frequently do you suffer from it? □ Constantly □ Frequently □ Intermittently □ Occasionally

What factors aggravate your pain? _____

What factors relieve your pain? _____

Have you had Xrays/CT-scans or MRI's for this problem? □ NO □ YES If yes, where and when: _____

Have you been treated for this problem before? □ NO □ YES If yes, who and when: _____

Does the pain radiate (or travel to)? □ NO □ YES If yes, where? _____

Do you have restriction of motion? □ NO □ YES If yes, where? _____

Have you experienced any weakness? □ NO □ YES If yes, where? _____

Date: _____ Patient Name: _____

Please tick (√) all conditions which you have experienced to date, and circle (O) the ones you are experiencing now:

GENERAL SYMPTOMS	EARS, EYES & THROAT	RESPIRATORY	MUSCLE AND JOINT	GASTROINTESTINAL
headaches	blurred vision	asthma	stiff neck	poor appetite
loss of consciousness	eye pain	persistent cough	neck pain	difficult digestion excessive
weakness	visual disturbances	difficult breathing	backache	excessive thirst
fainting	ear infections	spitting up phlegm	disc herniation	belching or gas
dizziness	ringing in ears	wheezing	swollen joints	nausea
fatigue	deafness	emphysema	painful tail bone	vomiting
loss of sleep	speech problems	chest pains	shoulder pain	constipation
loss of weight	thyroid problems	rib pain	knee pain	liver trouble
allergies	sinus infections	pressure in chest	hip pain arthritis	gall bladder trouble

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

appendicitis	whooping cough	diabetes	mental disorder	**FOR WOMEN ONLY:**
scarlet fever	anemia	cancer	hormonal disorder	painful menstruation
diptheria	measles	heart disease	eczema	excessive flow
typhoid fever	mumps	goiter	gout	hot flashes
pneumonia	small pox	alcoholism	hypertension	irregular cycles
rheumatic fever	chicken pox	epilepsy	rheumatoid arthritis	cramps

Do you have any other health problem not mentioned above? _____

Have you recieved chiropractic care before? □ YES □ NO If YES, date of last visit: _____

What was the chiropractor's name? _____ Explain results: _____

MOST RECENT VISIT TO A DOCTOR: *When was the last time you consulted a doctor, and for what reason?*

_____

Date of last complete physical exam: _____ **Date of most recent lab/blood tests:** _____

Familly History of illnesses of Father: _____**Mother:** _____

Siblings: _____

Past medical procedures, hospitalizations, major injuries, and serious illnesses: Please list all previous medical procedures, surgeries, hospitalizations, and serious illnesses. Use reverse of page if needed.

Approximate date/ year	**Surgery/ hospitalizations/ procuredure/ serious illness/ injuries**

DIET*: Do you follow any particular diet regimens or restrictions*? _____
EXERCISE: *Do you exercise regularly? If YES—what do you do? If NO—what keeps you from exercising?*
_____
HABITS and LIFESTYLE: *Please circle or list which of the following you use:* tobacco/cigarettes alcohol/coffee black tea cola/soda aspirin/ Tylenol/ analgesics antacids recreational drugs/prescription drugs
Other: _____

Current <u>prescription medications</u>, **<u>non-prescription medication</u> and/or <u>health supplements</u>** (e.g., vitamins, minerals, herbs): *Please list the medications and/or supplements that you are currently taking, with dosages:*

NAME *of medication or supplements,vitamins, herbs,*	**DOSE** *in milligrams or grams*	**FREQUENCY:** *Times per day/ week/ month*	**DURATION:** *Been taking for how long?*

Use reverse of sheet if you need to add more.